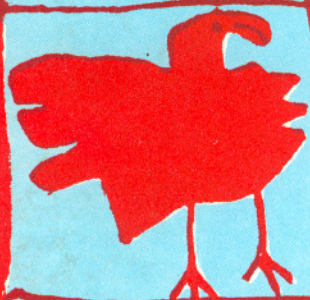


# phoenix rising

*Lovell*

## Kids+Psychiatry



**Incest**

**Ritalin**

**Tent  
City**

**Books**

**Special  
Ed**



**kids +  
the law**

**Pro-  
files**

**and more**

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WOMEN AGAINST PSYCHIATRIC ASSAULT,  
1744 University Ave., Rm. 123, Berkeley,  
CA 94703.
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Box 5728, Santa Monica, CA 90405.

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PHOENIX RISING will do its best to keep this list up to date. It will not be published in every issue, but the current list can be obtained at any time from PHOENIX RISING (see ad elsewhere in this issue). Please keep us informed of additions, deletions, and changes of name or address. Send corrections to: Group List, PHOENIX RISING, Box 7251, Station A, Toronto, Ontario M5W 1X9.





*Through the fire*

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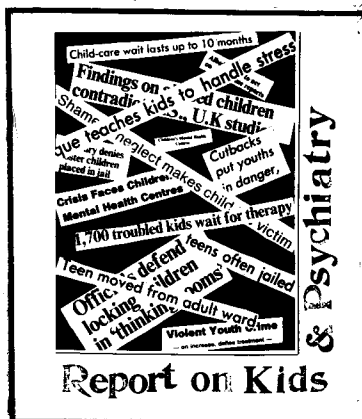
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EDITORIAL

# Let's start taking kids seriously

The similarities between children and "mental patients" are more than just coincidental. Both groups represent lack of restraint or order to our society and possess the free spirit that most adults have long since put aside to pursue more practical matters.

There are those of us who'd like to forget these small people who disrupt our lives, make us question what we've come to accept, and hold us accountable for our actions. They'd like to legislate them out of our apartments, out of our neighbourhoods and restaurants and out of our lives.

Because of this underlying intolerance for the different, we are still no closer to providing a tight network of services for troubled children, despite all the reports and studies that were generated during the International Year of the Child, and before that with the Commission on Emotional and Learning Disorders in children (CELDIC). Nor have we learned to accept children as equally important, if less experienced, individuals.

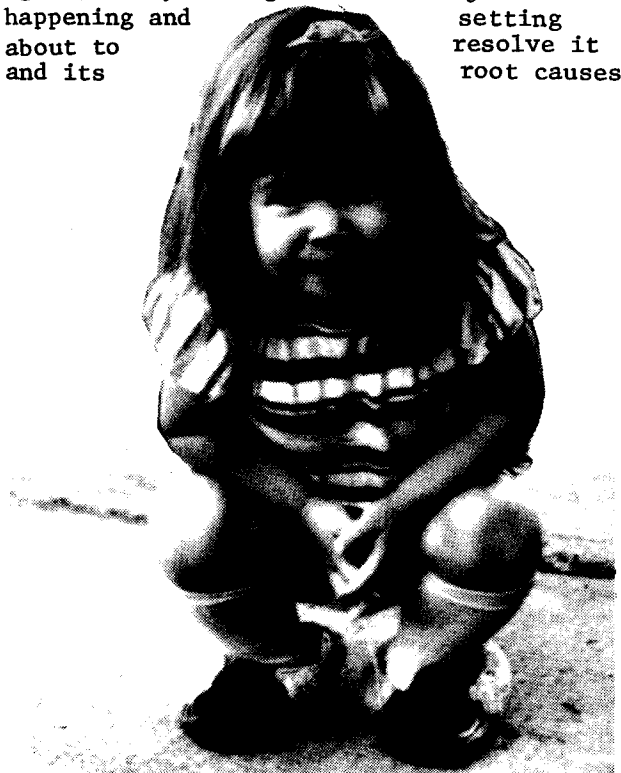
There would be no need for calls for a Children's Bureau or direct funding to children's services if we put the money and effort into developing and improving the services we already have so that they would *really* accomplish what they had been set up to do.

In the present-day climate of cutbacks and tight money, children and children's services are considered expendable. Small children cannot fight for their rights, nor have they reached a level of sophistication to know what they need. It is up to us to protect those rights and ensure that important services continue to operate and that those that are destructive are closed down.

Our record up to this point has been bad. We have neglected our role as caretakers and guardians of the future for the pleasure of the moment. But we are already beginning to pay in spades for what we have ignored earlier. The number of children who are troubled is growing

rapidly, and they are making themselves known through violence, directed either outward at anything in their way, or inward through suicide of one form or another.

We can react to this violence in one of two ways: either by attempting to re-establish law and order through force or coercion and hope that it won't flare up again, or by asking ourselves *why* it is happening and setting about to resolve it and its root causes.



Annegret Lamure

The behaviour of our children is a barometer of what really ails our society. Children only mirror our behaviour. We cannot change our world by gagging our children, by locking them up, or by using extreme forms of behaviour modification, drugging or shock.

We must look deeply into ourselves and examine the way we relate to each other for the answers. Then perhaps we will be prepared to deal with children in the manner they deserve.

CONTRIBUTORS: Jeffery Wilson, Paul Weinberg, Ian Orenstein, Morty Goldmacher, Nancy Masters, David Melville, Barbara Kelly, Jay Schumacher, Allan Tenebaum. Special thanks to Murial Armstrong, Sandi Champion, Connie Neil and Scott Carthew. The junior artists of this magazine are: Michael Steven, 5, and Christine Hurrle, 6. The front cover depicting a child being given a needle by a doctor was done by Michael.





# write on

NOTE TO READERS: *Phoenix Rising* assumes any correspondence sent to us may be reprinted in our letters section unless otherwise specified. Please tell us if you would like your name withheld if your letter is printed. Letters without names and addresses will not be accepted.

★ ★ ★ ★

Congratulations on a super first year. Enclosed is a cheque to renew my subscription and to order back issues.

I have foolishly let people borrow your magazine: a sure sign of impact is that no one ever returns the *Phoenix*. From now on I tell them to subscribe. right?

*Al Erlenbusch,  
Toronto, Ont.*

★ ★ ★ ★

I am an ex-mental health patient and was admitted several times to the Clarke Institute of Psychiatry. I am now fully recovered and not on any medication and just thought I would do something that might stimulate some thinking in mental patients:

## In Defense of Psychiatrists

Ever wondered why?.....

- Psychiatrists make that much money?
- Psychiatrists have the highest suicide rate of all other professions?
- Psychiatrists just give out dope?
- Psychiatrists are so busy?
- Psychiatrists are opting out of O.H.I.P.?
- Psychiatrists are so frustrated?

my ideas are...

- they studied for a long time and work their asses off. For what?
- their patients' problems become their own--they live the problems of their patients
- frustration
- no one ever gets cured

- they need more incentive and rewards
- no progress

*Paul Gomes  
Toronto, Ontario.*

★ ★ ★ ★

I have just finished your Spring 1981 issue--a highly professional job. Congratulations. What you have accomplished with slender resources and a small staff is amazing.

David Reville's article about his experiences in Kingston Psychiatric Hospital made a deep impression on me. I admire both his guts and his writing ability. Too bad I don't live in Ward 7; I'd like to vote for him.

In your piece about drop-out doctors you advise readers to go to a doctor who is still in OHIP--if they can find one. The Metropolitan Toronto Branch of the Canadian Mental Health Association can supply that information. Their new booklet *Coping with Stress in Toronto*, advertised on your back cover, says on page 37 that their files "include details on psychiatrists regarding areas of specialty, office hours, participation in OHIP, cultures understood and languages spoken." So phone CMHA/Metro at 789-7957, let them know what information you need, and they'll tell you.

*Norm Houghton,  
Toronto, Ont.*

★ ★ ★ ★

I was extremely fortunate to be introduced to your publication "Phoenix Rising" and overjoyed with the concept of the magazine.

I've been employed with several psychology departments as a psychometrist and counsellor for eleven years, four of those years served in Psychiatric institutions. I must admit I've seen a few changes happening with respect to human-patients' rights but as you are

aware we sure have a long way to go in erasing the injustices and poor service provided by our system of mental health care.

Three cheers for Mavis MacKenzie! (Spring 1981 issue). I certainly support all her recommendations concerning changes within service delivery. Personally I find her second suggestion regarding "... communications between hospital staff and patients ..." an area where neglect exists. It's truly amazing how so little interaction does exist between patients and helping professionals due to professional perspectives on human problems!

Myself, along with a few colleagues, will endeavour to make as many people aware of your magazine as possible and are happy to know it will soon be available on the stands. The efforts of you and your staff will, I know, continue to result in one of the most significant thrusts in the betterment of the human condition.

*Don Cormin  
Dartmouth, N.S.*



I have just received a letter from Marilyn Rice, "Truth in Psychiatry", and she has been in touch with you, about a statement by Leonard Roy Frank, quoting Dr. Szasz who says "the mind ... is not an organ or a part of the body. Hence it cannot be diseased in the same sense as the body can".

I met Dr. Szasz about three years ago, along with Dr. Desmond Kelly, Ian Kennedy, a law tutor, and Dr. Clare who is a member of the Association for Mental Health, or MIND. Dr. Kelly is the chairman of the Committee for Prevention and Treatment of Depression, and we keep in touch. Ian Kennedy was last year's Reith Lecturer, BBC (each year one notable person gives a series of six lectures)... He spoke on UNMASKING MEDICINE, has repeated this since with a discussion "UNMASKING MEDICINE?" with other doctors and one M.P.

Dr. Clare, I don't bother about, since MIND are more concerned with their IMAGE rather than actually doing anything for people, and here in this town, I take on the local MIND group's failures. Their psychiatrist chairman thinks that pills and ECT will take the place of friends, when people are lonely. After three years or so, they give up paying for private therapy and visit me instead.

I have two voluntary "assistants" who have improved mentally within two visits, and are delighted to help me now, becoming more confident each time we get together. We build up confidence, and use people's own talents to encourage them back to full normality.

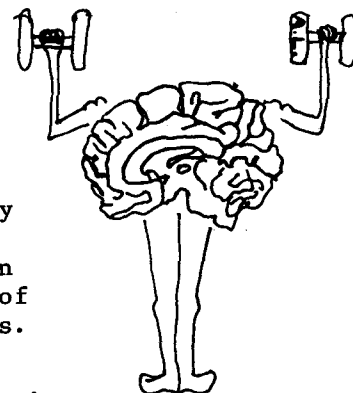
## *"We believe the brain is like a muscle..."*

We believe that the brain is like a muscle. If we don't use our muscles, they go flabby. After years of schooling, with the mind reaching a certain pace, then if that pace is altered in any way, then the mind will not only go flabby but will start to work "backwards". People look inwards upon themselves and backwards towards the past. What we try to do is to get the mind working forward again.

We are getting a little tired of journalists, for although we repeat this to each one who asks for our information, they just carry on writing their articles with their ideas, and are always far from correct.

Mary Kenny, here in England has quoted Maggie Scarf of New York. Maggie says that men and women have different reasons for depression. Women are more emotional, while men suffer from loss of dignity, etc.

I get many men coming to visit me, for consultations, who have great emotional problems, brought on by bad upbringing, and learning the wrong things in their childhood childhood days. Their parents make them feel guilty still, when as adults these men want to follow their own instincts but are still emotionally blackmailed by their parents, who in fact are not models of perfection themselves.



P.S. I take little notice of any self-styled experts.

*Janet Stevenson  
Depressives Associated  
Dorset, England.*



Regarding the article in the Spring issue of *Phoenix Rising* written by David Reville caused me to reflect upon my own experience with Kingston Psychiatric Hospital.

My experience began in November of 1975. I had been an inpatient of the Clarke Institute of Psychiatry for a few

## *"I was referred to as Miss Clarke Institute..."*

months and their treatments (medication) did not seem to be effective. I was not liked by the hospital staff--probably because I was a "shit disturber" and I had been an inpatient of the Clarke many times prior to this. I was referred to sarcastically several times as "Miss Clarke Institute" by staff members.

One morning shortly after breakfast I was informed that I was going to be transferred to Kingston Psychiatric Hospital. I was to leave in 20 minutes. I had been given no warning, nor had I been consulted in any way about this transfer. So I was given 10 milligrams of liquid valium (this was on top of six other medications I had been put on) and off I went to Kingston Psychiatric Hospital by ambulance.

NOTE: I found out years later that they had done this transfer illegally. Kingston Psychiatric Hospital was the district hospital for the address of my parents. They used their address--which had never been my address, and I had been living away from my parents for several years.

On the trip to Kingston I was accompanied by the head nurse and an occupational therapist from the Clarke. The head nurse brought along two more 10 milligram tablets of valium which I was given on the way.

By the time I got to Kingston I was "stoned" on valium. I could hardly walk. As soon as I was admitted to the ward I was locked in a small, bare, cold room which they called the "quiet" room. I say cold because the window was kept open from the outside and in November it starts getting quite cold.

For the first week I was not allowed any clothing--they said that this was because all my clothes had been taken to have labels sewn on them for identification purposes. This was standard pro-

# In our next issue...

**THE INTERNATIONAL MOVEMENT (with a special section on Canadian groups)**

**Injectables - a 1984 answer to tranquility**

cedure.

At K.P.H. I was given no medication except for birth control pills (I was already on) and vitamin B. They diagnosed me as having behaviour problems and the treatment was behaviour modification. This treatment meant being locked in the "quiet room" for hours on end for any kind of inappropriate behaviour--which was determined by the staff.

One example of my inappropriate behaviour was not making my bed one morning. When I was told to make it and I did not respond immediately, a male staff came up from behind me and put his arm across my face which caused my nose to bleed. For this I was locked up.

## *"I stepped into a bar..."*

Well, the day came about 3 weeks after admission that I was allowed out on the grounds with permission from the staff. On my first day outside I could not resist the temptation of walking a few blocks away from the grounds. I stepped into a bar for a beer. As if fate was totally against me, when I got back it had been reported that I had been seen in town. So another couple of days of confinement to the ward.

Most of the month I was in K.P.H. however I mainly thought of how I could get back to Toronto. What really got me moving was a phone call from my boyfriend (who I had been living with up until I had been placed in K.P.H.) He had gone to visit me in the Clarke the day I left for Kingston but due to financial problems he could not afford to call me until this point.

The next day I had a chat with the





# ON OUR OWN

## NEW FACES

\*\*\*\*\*

There are some new faces around the ON OUR OWN office and The Mad Market.

At the end of July, Coreen Gilligan resigned as Mad Market Manager. We're sorry to see her go, but delighted to know she's planning to stay involved with the store and on some ON OUR OWN committees. Taking her place as Acting Manager for a few weeks is Liz Lovell, who has been working in the store on a Work Adjustment Training program and doing very well indeed.

Bookkeeper Mike Mallon has been on staff since June, replacing a much missed Steve Anderson; Sandi Champion, our new office manager, started at the same time. Already the offices are less messy and more organized.



*Sandi Champion*

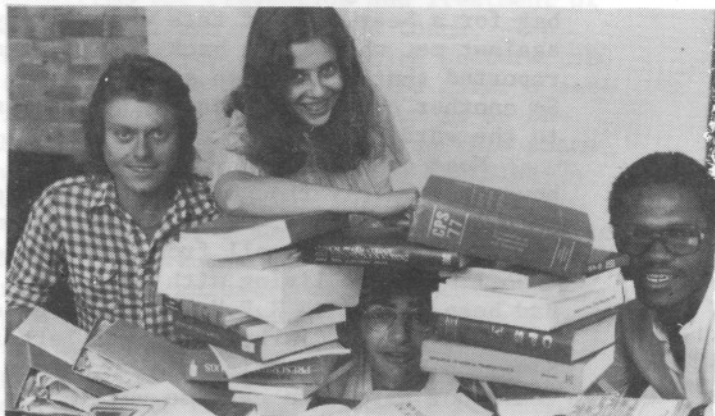


*Mike Mallon*

### welcome

### aboard

Four students joined us at 67A Portland Street during the summer to research and write a consumer's guide to psychiatric drugs as a summer student employment project. They are Abbe Edelson, Allan Tenebaum, Jeffrey Solate and Larry Sargent. We plan to publish their work in the near future, and hope they stay involved with us after they resume their studies.



*Our students from left to right: Larry Sargent, Abbe Edelson, Allan Tenebaum (in the books) and Jeffrey Solate.*

\*\*\*\*\*

Stay tuned for a TV Ontario (Channel 10) special on ON OUR OWN and HouseLink members Steve Anderson and Liz Lovell. Steve and Liz star in a documentary on the problems and triumphs ex-inmates experience after they come out of psychiatric institutions. The documentary is one of a series this station has been running on the "disabled" for International year of the Disabled. It'll be aired sometime in October or November.

\*\*\*\*\*

# Tent city Toronto

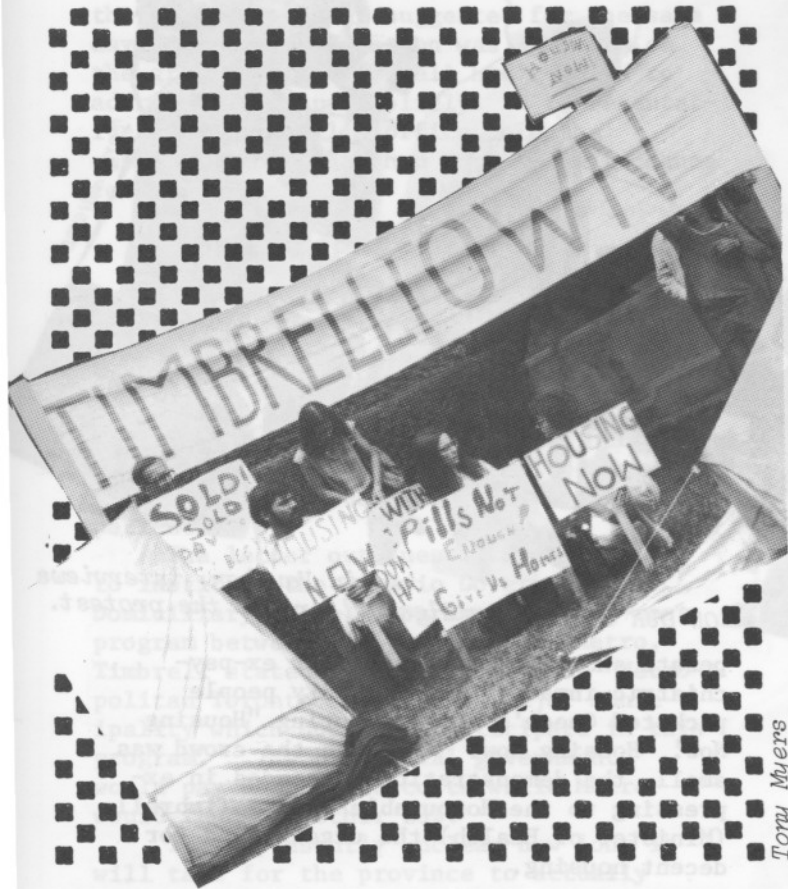
"WHAT DO YOU WANT?"  
 "HOUSING!"  
 "WHEN D'YA WANT IT?"  
 "NOW!"

## The Queen's Park Demonstration

"HOUSING FOR FORMER PSYCHIATRIC PATIENTS BECOMES MORE CRITICAL" "PARKDALE FIRE, CLOSING OF ROOMING HOUSES LEAVES 60 EX MENTAL PATIENTS HOMELESS".

Toronto's establishment press, as reflected by these headlines in June, is finally waking up to the fact that there's a critical and cronic housing crisis for former psychiatric inmates. It's not really news. During the past five years, the housing shortage has steadily escalated, forcing ON OUR OWN and others to take increasing action to press for change.

Two recent reports from the Metropolitan Toronto Subcommittee on boarding Homes and Lodging Houses (1979, 1980), two position papers from CRC (Community Resources Consultants) (1978, 1979), and



Tony Myers

## GIVING THEM THE BIRD

Phoenix Feather number five goes to a Toronto lawyer who has, over the last couple of years, been battling for the rights of psychiatric inmates and other handicapped people working in sheltered workshops.



Last year, David Baker won workshop employees coverage under Workmen's Compensation. This year he followed up that victory with a decision making this coverage retroactive,

so that all sheltered workshop employees injured *before* the original decision can claim compensation. He is now engaged in arguing a case which may decide that workshop employees should receive minimum wage; a decision is expected some time this fall.

David is Executive Director of the Advocacy Resource Centre for the Handicapped, a legal aid clinic serving

handicapped people, including psychiatric inmates. For his dedication to the right of handicapped people in general and psychiatric inmates in particular -- the Phoenix Feather.

The Turkey Tail award for this issue goes to the English Social Services



authorities in Leigh, near Manchester. Authorities told Harry and Ester Hough they could not adopt a child because their home was "too happy". Said the authorities, "It

would seem from the interviews and reports that both of you had few, if any, negative experiences when children yourselves, and also seem to enjoy a marital relationship where rows and arguments have no place."

The couple have been foster parents to 47 children.

one produced jointly by CRC and the Clarke Institute of Psychiatry this year (see news section) have clearly documented facts such as these:

- There are only forty to fifty commercial boarding houses in Toronto, containing 730 to 750 beds for recently released inmates.
- At least half of these boarding houses are substandard, grossly inadequate, and riddled with health, building and fire violations.
- Boarding houses are predominantly owned by private operators, who typically exploit and patronize the residents.
- Roughly three-quarters of the city's boarding houses are located in the South Parkdale area in Toronto's West End.
- There are very few other types of housing for ex-psychiatric inmates except for HouseLink, which has about twelve co-ops, all resident-controlled, with sixty to sixty-five beds.
- The vast majority of residents in boarding and lodging houses and other subsidized housing are poor and receiving welfare or Family Benefits disability allowances or pensions.



Colin Vaughan, interviews ON OUR OWN member Glen Walters at the protest.

perate shortage of housing for ex-psychiatric inmates. About forty people picketed Queen's Park, shouting "Housing Now! Housing Now! Although the crowd was small, the demonstration succeeded in expressing to the Honourable Dennis Timbrell (Minister of Health) the urgent need for decent housing.

## Government does nothing

- Governments on all levels have done virtually nothing to relieve or solve the housing crisis. A scandalous lack of planning, co-ordination and funding has blocked effective action.
- Psychiatric institutional staff generally do not refer and follow up inmates with serious housing needs or problems.
- Lack of decent and affordable housing, together with unemployment is forcing many people back into psychiatric institutions--a waste of lives and money.

The housing crisis became even more critical and visible in June when two fires in two Parkdale boarding houses and the abrupt closing of a third resulted in over sixty ex-psychiatric inmates suddenly finding themselves homeless. Direct and quick action was needed.

## Crisis forces people to hostels

The Housing Crisis Committee, a coalition of ON OUR OWN and PARC, organized a successful public demonstration at Queen's Park on June 30 to protest the provincial government's lack of action on the des-

## "Timbrelltown"

A group of tents pitched on the lawn in front of the Legislature had much visual impact, with a banner designating the site as "Timbrelltown" clearly illustrated that ex-psychiatric inmates forced to wander the streets and live temporarily in overnight hostels require immediate emergency accommodation.

Mel Starkman, ON OUR OWN member of the Housing Crisis Committee, introduced several notable speakers including David Reville (Alderman for Ward Two), Dr. Tyrone Turner, Tony Ruprecht (MPP for Parkdale), and Robin White, who came out to show their support, as well as addressing the audience. Pat Capponi also delivered a moving speech.

## Timbrell doesn't show ...

The Housing Crisis Committee invited Dennis Timbrell to address the crowd. However, Timbrell refused to appear at the demonstration. Instead he offered to meet privately with three representatives from the committee. Although the Housing Crisis



Committee was open to meeting with Timbrell, the private meeting suggested for the same day as the demonstration was rejected on the grounds that Timbrell had refused to address the issue publicly. A representative from Timbrell's office told the committee that they had missed their chance for a meeting.

### Replies in letter

Despite Timbrell's unwillingness to address the demonstration in person, his response to the crisis appeared in a letter to the editor of the Globe & Mail on July 7. In this letter Timbrell attempted to "correct for your readers [sic] an impression which may have resulted from your report on housing for ex-psychiatric patients."

The letter outlines Timbrell's plans to institute the Ontario Government Domiciliary Hostel program, a shared-cost program between the province and Metro. Timbrell stated in his letter that "Metropolitan Toronto is the only major municipality which does not participate in this program." The provincial government would pay 80% of the costs while Metro would fund the other 20%.

It is presently unclear how long it will take for the province to actually implement the program, and whether or not it will offer any long-term solutions. According to Mary Stern, the hostel program does not solve "the literal question of short-term survival. ...We are still waiting for some emergency plans."

If you are interested in becoming involved with the Patients' Housing Crisis Committee, contact Mel Starkman at 362-3193.

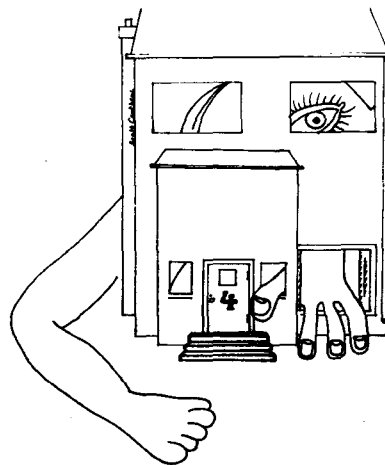
### Full Time Job Treading Water

That couldn't be a rat, nah  
- it's just a pregnant mouse.  
The cockroaches are multiplying  
with ardent fervor.

Last pack of tobacco, stolen by moonlight.  
Stomach mumbling and grumbling,  
No one has money in the house.  
Maybe panhandle for a coffee,  
Not too much to sing over.

Call me names, treat me as strange.  
Even if life isn't too sweet,  
It is always too short.  
Push me into the ground,  
But a promise is a promise.

I'll keep popping up,  
Along the evergreen line. *by Frank Farkas*



### Domiciliary Hostels

In response to the Patients' Housing Crisis Committee demonstration of June 30, 1981 the Hon. Dennis Timbrell, Minister of Health in the Tory government, has offered Metro the Domiciliary Housing Program.

The proposed move by the Ontario government towards domiciliary hostels in Toronto will be taking this province even further away from really coming to grips with the housing problem.

The Domiciliary Hostel Program already in operation in Windsor, Hamilton and Ottawa is bringing "Back Wards to Back Streets" to Ontario, lobbied for and run by the Rest and Lodging Home Association. It is a private entrepreneurial thrust with an eye to profits, not people. Already Windsor has an over-200 bed facility where the staff wear white uniforms. This is a return to *institutionalization*. But unlike Ontario's Homes for Special Care, which are usually found in rural and urban peripheral areas, Domiciliary Hostels will likely be located in urban centres where they will act as dumping grounds for lower income ex-inmates.

At least one very concerned Supportive Housing Coalition (SHC) participant has indicated that we cannot allow the hospital superintendents to get away with defusing the crisis by dumping inmates, many of them in the "at risk" category, into new boarding houses under the name of domiciliary hostels.

Paul Godfrey, Metro Toronto Chairman, is resisting the pressure from Timbrell to put the domiciliary hostels in place. Metro will not come up with its 20% share. Concerned workers hope that this is not just penny-pinching, but a clear message to the provincial government that better programs must be worked out if Metro is to participate.

# Survey Says People Drugged Against Their Will

A press conference held by a coalition of "mental health" and "patient rights" advocacy groups in Toronto, including ON OUR OWN, over the treatment of psychiatric patients received good media coverage. All three Toronto newspapers, Canadian Press, and several radio and television stations covered the event. It may have to take another drug-induced death like Aldo Alviani last year, however, before the provincial government satisfies the participants' demands for a public inquiry.

So far the Ministry of Health only committed itself to doing an in-house inquiry into the operations of its mental health facilities, conducted by psychiatrist, Dr. Gilbert Hesetine, formerly head of the Department of Psychology at the University of Western Ontario.

The results of the survey distributed by ON OUR OWN, Houselink, Community Homes, the Canadian Mental Health Association, Metro and Ontario branches - the Patients' Rights Association, Friends and Advocates, the Ontario Association for the Mentally

Retarded and the Toronto chapter of the Medical Reform Group were based on the responses of 110 inmates who had been hospitalized since November 1, 1978, when the current Ontario Mental Health Act was proclaimed. The results of the survey were presented to the media on July 23 at the Advocacy Resource Centre for the Handicapped (ARCH).

While the results were not representative of all of Ontario's psychiatric inmates - it was

weighed towards inmates in public psychiatric hospitals rather than in general hospital psychiatric wards - the survey did find that psychiatric patients are routinely given little or no information about their treatment and their right to refuse treatment. The survey found that many patients were given drugs even when they did exercise their right to refuse, contravening present Ontario laws.

Of a total of 206 admissions to 40 different hospitals, 195 ended up receiving medication. During 21, electroconvulsive therapy (shock therapy) was given.

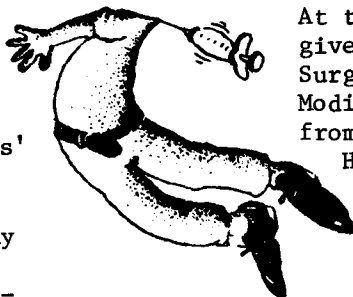
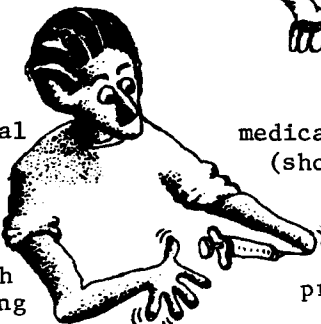
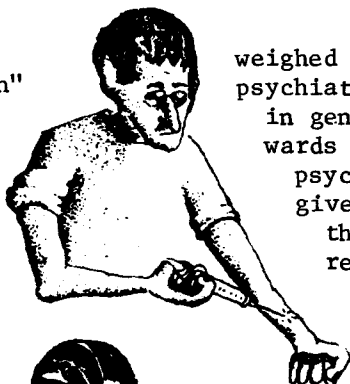
In 70% of the cases, respondents were told nothing of the harmful effects of the drugs, many of which cause tardive dyskinesia, a permanent degeneration of the nervous system.

Carla McKague, an articling student at ARCH, who was acting as counsel for the coalition told reporters the results of the survey were only "the tip of the iceberg", and challenged the Ministry of Health to do their own survey to prove whether the problems indicated in the results were as widespread as the coalition suspected.

At the press conference reporters were also given copies of a 1981 ruling of Physicians and Surgeons of Ontario by a woman who was given Moditen and experienced severe side effects from the drug causing tardive dyskinesia.

Her doctor testified that he did not know tardive dyskinesia was a common side effect of the drug. The complaints committee of the College of Physicians and Surgeons did not criticize the doctor's method of treatment, but did chastize the doctor for not advising the "patient" of the serious permanent side-effects of the drug. The committee cited literature from the last thirty years that have indicated close to 40% of "patients" receiving long-term "antipsychotic medication may develop tardive dyskinesia" in the final decision.

The 9th Annual International Conference on Human Rights and Psychiatric Oppression was held this year in Cleveland, Ohio. Look for a full report of this conference in our next issue.



State and Mind



# the Book worm turns

The Powers of Psychiatry, by Jonas Robitscher. Boston: Houghton Mifflin (1980), 557 pages, \$17.95 U.S. (about \$22.00 Canadian).

Reviewed by *Carla McKague*

Jonas Robitscher writes about psychiatry from an almost unique perspective: he is both a psychiatrist/psychoanalyst and a professor of law. From that vantage point, he has written a thoughtful and compelling book on the invasion of our daily lives by psychiatry.

The Powers of Psychiatry is not an easy book to read; it is scholarly in tone, and a little ponderous. And it is also a little schizophrenic. Robitscher sees very clearly the problems that arise when psychiatry extends its domain beyond the field of "mental illness", but walks a philosophical tightrope when he is dealing with what many people would see as its proper sphere.

Consequently, the parts of the book on psychiatry proper are filled with "on the one hand ... on the other hand" statements. Robitscher carefully doesn't put his stamp on the medical model of "mental illness", but doesn't disown it either. He states that he doesn't use shock therapy in his own practice, but concedes that it has produced some good results. (He is apparently not up on the latest studies on shock, which challenge that statement very strongly. He recognizes that therapeutic abuses occur, but does not see the system itself as abusive. In other words, one of Robitscher's conclusions seems to be that psychiatry is all right so long as it knows its place, which is helping people with severe emotional problems.

The importance of the book, however, lies in its critical examination of the ways in which psychiatrists have insinuated themselves into fields in which they have no expertise, no valuable contribution to make, and--in short--no business. And these fields are legion.

Take the courtroom, for example. Psychiatrists by the hundreds appear in North American courtrooms every day to inform judges and juries about whether accused criminals are "fit to stand trial", or legally "insane", or "dangerous". They are not qualified to make *any* of these judgements, as has been demonstrated over and over again by studies.



Another way in which our legal process employs psychiatrists is by empowering them to make decisions about civil commitment. Often here, as in the criminal process, what is at issue is the individual's alleged dangerousness--and psychiatrists are no better equipped than anyone else to predict dangerousness. We also give psychiatrists the power to decide whether people are competent to manage their own money; there is no reason to suppose that psychiatrists have any special expertise in making this decision. But that is only the beginning. Industry now employs psychiatrists to determine whether people are suited to their jobs (or, more often, to the jobs they are applying for). Psychiatrists evaluate prospective adoptive parents to see if they are fit to care for children. Psychiatrists make decisions about whether mentally handicapped people should be sterilized--and, in fact, may be called in even when the candidate for sterilization is perfectly normal mentally to make sure he or she *really* wants to be done with child-bearing or begetting.

Psychiatrists help choose among the many people who need the use of the few dialysis machines available, condemning the others to death. They are hired by government agencies to prepare psychological profiles of (usually unfriendly) world leaders to assist politicians and espionage agencies in their work. They conduct experiments such as those in



brainwashing run in Montreal in the sixties, and on the basis of which five Canadians are suing the CIA, which commissioned them.

Perhaps most frightening of all, psychiatrists use the prestige of their profession to make public pronouncements which profoundly affect our society. It is *psychiatrists* who decide whether homosexuality is really "normal" or "abnormal", whether Richard Nixon or Charles Manson is more to be pitied than censured, whether poverty and racism are bad things.

These are, admittedly, all questions that should be answered. But why by psychiatrists? What their job is, according to Robitscher, is to help people with their emotional difficulties (as mentioned, he shies carefully away from calling them "illnesses"). But somehow our society has bought the myth that, because they apparently know so much about how people's minds work, they are experts on everything involving the mind--which means virtually everything. We look to them for answers, and they, flattered by the attention, provide them. Unavoidably they come to believe, if they didn't already, that they *do* have some special sort of knowledge that makes their opinions more valuable than those of housewives, economists, bricklayers and lawyers; and with this belief in their infallibility comes, also unavoidably, a seizing of the power to impose their decisions on others.

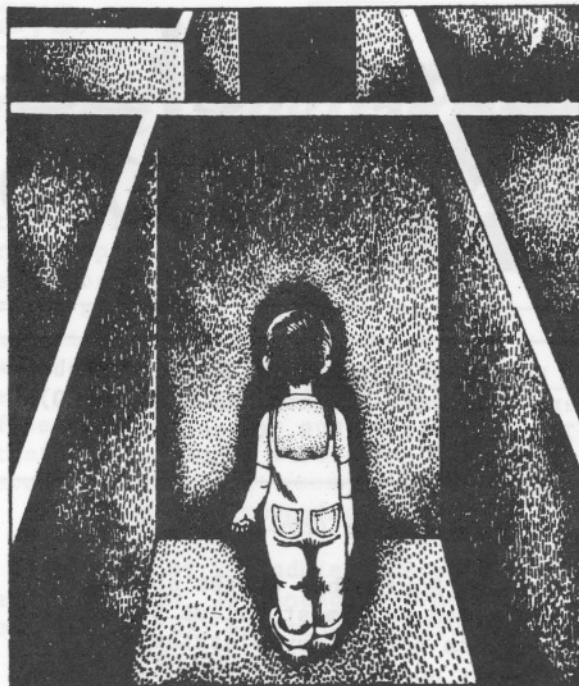
Robitscher issues a call for the rest of us to challenge the psychiatrists and take control of our lives back into our own hands. It can't happen too soon.

The Myth of the Hyperactive Child and Other Means of Child Control, by Peter Schrag and Diane Divoky. New York: Random House, 1975, \$12.95 hardback, 280 pages.

Reviewed by *Bonnie Armstrong*

In the past 15 to 20 years, there has been a drastic change in the way North American institutions treat children. Traditional forms of punishment and control are rapidly being replaced by psycho-social and psycho-chemical techniques to breed conformity.

The book *The Myth of the Hyperactive Child* gives a very detailed picture of the methods used by teachers, school administrators and juvenile authorities to "make children more manageable". It is written from an American perspective and the inci-



TCB/cpf

dents described in the book take place in the early seventies. Although it's difficult to know if the situations described in this book are happening in Canada, I would suspect that the situation is probably pretty much the same, albeit altered by time, because of the strong similarities between the two countries.

The authors of this book believe many children who suffer from no scientifically demonstrated disease are being labelled by professionals merely because they appear troublesome to adults. They outline new forms of treatment being used such as psychiatric drugs, behavior modification and testing and screening of children for learning disabilities, emotional problems and "pre-delinquency". These are intended to eliminate all forms of "undesirable behavior".

The reason for such labelling and testing, the authors believe, is to determine a medical problem requiring a medical treatment. Often these labels are far more imagined than real.

A case in point is hyperactivity. In the chapter entitled "The Smart Pill", Schrag and Divoky describe the wide-spread use of Ritalin and others like it to "cure" hyperactivity, and the abuse of these drugs by American school systems. Kids are put on these drugs for a variety of reasons ranging from personality clashes with teachers and short attention spans to "disturbing questions". Although some kids seem to benefit from their use, the drugs can have some dangerous side-effects (pages 85-86):

"In one case a six-year-old on Ritalin first became cranky and plaintive, then co-operative and relaxed, but after a week she started to show 'grossly bizarre' behaviour, hiding in a closet and cowering in a corner, becoming apathetic and mute, 'almost like a vegetable', then babbling incoherently, staring into space, and contorting her body. In another case a ten-year-old boy started screaming in his sleep on the second day of Ritalin regime, then becoming irritable, more hyperactive and physically abusive to younger children, saying that he 'felt like he wanted to tear everything apart'. He saw animals marching around a whirlpool; food assumed a strange taste and his mouth went dry. Later he became weak and depressed."

Psychologists such as Mark Stewart of the University of Iowa who have studied the long-term use of stimulants like Ritalin are also quoted in this book (page 87):

"They come off the drugs at fourteen or so, and suddenly they're big, strong people who've never had to spend any time building any controls in learning how to cope with their daily stress. Then the parents, who have forgotten what the child's real personality was like without the mask of the drug, panic and say, 'help me, I don't know what to do with him. He's taller than I am and he has the self-discipline of a six-year-old.' At that point the parent sees the only solution as going back to the drug. They can only deal with the medicated child; that's the seductiveness of successful drug treatment—that it temporarily solves the problem without asking the people involved to do anything."

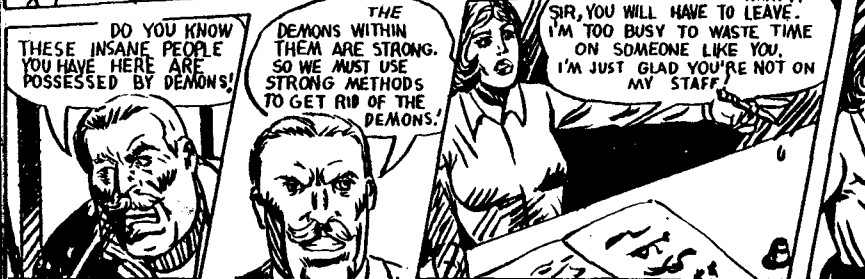
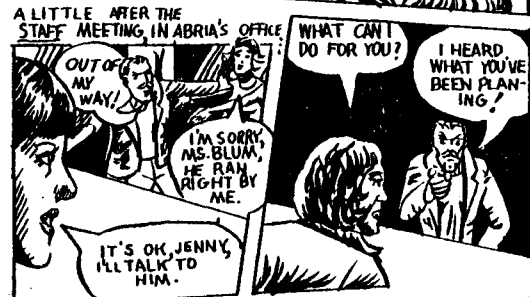
With regards to "predelinquency", the book relates cases where undercover agents have been known to enter schools posing as students to try and determine which students use drugs or are likely to use them in the future. The information they collect

# ABRIA

By Ian Orenstein

**Our Tale:** ABRIA BLUM CALLS A STAFF ASSEMBLY TO STOP A STRIKE OVER HER CHANGES AT THE FLORENCE MONTROSE HOSPITAL. THE PATIENTS, AT THE SAME TIME, HAVE THEIR OWN MEETING.

IF WE'RE TO VOTE, WE NEED A MOTION TO VOTE ON. I HAVE THE WORDING: "WE THE PATIENTS OF THE FLORENCE MONTROSE HOSPITAL SUPPORT THE NEW DIRECTOR'S RIGHT TO IMPROVE THE CARE HERE."



often ends up on the students' school records or in a police file centralized data bank.

*The Myth of the Hyperactive Child and Other Means of Child Control* is a mixture of both technical information and personal experiences of parents, children and pro-

fessionals. It goes beyond a superficial look at labelling children and raises important political and philosophical questions. This book should be necessary reading for all those interested in the education of children and its implications for the future.

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Prepared by Cathy McPherson,  
Annegret Lamure and Don Weitz.

Allen, Charlotte Vale. *Daddy's Girl: A Very Personal Memoir*. Toronto: McClelland and Stewart (1980), \$14.95. A Toronto writer attempts to come to terms with her incestuous relationship with her father. The author documents the shame and fear that crippled her capacity to form caring relationships however she does not really resolve them. One is left with the distinct impression that Allen skirts around the central issue, but is not quite ready to come to grips with it.

Armstrong, Louise. *Kiss Daddy Goodnight: A Speakout on Incest*. New York: Hawthorn Books (1979), paper \$3.25. The author talked with 183 women who, as children, suffered sexual abuse by fathers and brothers and describes the experiences of sixteen of them. The accounts, linked together by the author's observations and comments explode many of the popular myths surrounding incest.

Bakan, David. *Slaughter of the Innocents: A Study of the Battered Child Phenomenon*. Toronto: CBC (1971), paper \$3.35. A noted psychologist makes a serious effort to understand the causes of child abuse and child murder. A lot of psychologizing but some interesting literary and historical material. Solutions include universal enforcement of articles 5 and 25 of the United Nations Universal Declaration of Human Rights.

Brady, Katherine. *Father's Days*. New York: Dell Publishing (1981) paper \$3.25. This is one of the best of all the books on the topic of incest because the author deals with her personal experiences squarely and forces her family to do the same. You may not agree with her method of dealing with her experience but you'll find yourself rooting for her - and her father - by the end of the book.

Gil, David G. *Violence Against Children: Physical Child Abuse in the United States*.

Boston: Harvard University Press (1970), \$6.50. A leading social scientist presents major and alarming findings of the first nationwide study of child abuse in North America (1967-1968 involving over 6,000 cases). Three major recommendations are suggested to change the present emphasis on physical force to "socialize" children.

Humphreys, Edward. *Privacy in Jeopardy: Student Records in Canada*. Toronto: The Ontario Institute for Studies in Education (1980), paper \$9.95. In this revealing study, Humphreys points out the potential for misuse of information in student records. While the author finds most schools and teachers presently respect the confidentiality of pupils and their parents, he predicts wider access to records with the advent of greater computer use by school systems in the future.

Shields, Mary Lou. *Sea Run: Surviving My Mother's Madness*. New York: Fitzhenry and Whiteside Ltd. (1981), \$15.95. A personal account of how a feminist comes to grips with her mother's madness and in the process teaches her psychiatrist a thing or two. A very positive book, but could have been more critical of psychotropic drug use.

Van Stolk, Mary. *The Battered Child in Canada*. Toronto: McClelland Stewart (1978), paper \$7.95. A well researched, hard-hitting overview of child abuse in Canada. The author chiefly blames health professionals - particularly doctors - for failing to correctly identify and report incidents of abuse and testify in court.

Weitz, Don. "We Still Lock Up Children". *Toronto Life*. May 1976, pp. 56-63. An expose of the common use of solitary confinement in Ontario's training schools. Much of the documentation of the many serious psychological effects of solitary is based on personal interviews with young ex-inmates punished in the "digger". (Copies can be ordered from Phoenix Rising, P.O. Box 7251, Station A, Toronto, Ont. M5W 1X9 for \$.75 plus postage).



# profiles

## Parents Anonymous

A beleaguered 29-year-old mother started Parents Anonymous eleven years ago when she couldn't cope with the stresses of raising her children. In California, under the name of Mothers Anonymous, she brought together a group of mothers with problems similar to hers for mutual support and encouragement. It changed its name to Parents' Anonymous in the early 70s.

There are now over 1,200 local chapters of this self-help organization in the United States and an estimated thirty-five in Canada, thirty of which are in Ontario.

The first Canadian chapter was opened in Burlington in 1972, a year later it was incorporated. The Parents Anonymous groups that have followed may employ the name, but not all belong to the umbrella organization.

As a crisis intervention organization, Parents Anonymous uses two methods of help: a 24-hour "hot line" and a weekly group meeting for parents who have abused their children or feel that they may abuse them. Volunteers who are members of Parents Anonymous return crisis calls. No one gets paid except for the answering service, the Managing Director of the Hamilton/Wentworth Burlington/Oakville Chapter (which is the national headquarters of Parents Anonymous), and her secretary.

Though there is usually only one person on call at a time, the volunteer quite often returns calls within five minutes. If for some reason he or she is swamped or cannot be reached at the number given for the shift, the answering service is provided with a back-up list of volunteers. At present, the Hamilton/Wentworth/Burlington/Oakville chapter has twenty-seven "hot line" volunteers. Last year National Headquarters handled over 2,100 calls from parents, and that



didn't even include crisis calls in Oakville, which only became incorporated in May of this year.

The weekly meetings are run by "sponsors", again experienced volunteers. They guide the parents in group discussions of how they handled or bungled situations with their kids. No authoritarian advice is given, no moral judgments made. Attendance is the main concern.

Sometimes Parents Anonymous will refer individuals, upon request, to the appropriate social agencies more suited to meeting their specific needs. Sometimes personal contacts are made, but that is rarer still, since the frequent shortage of volunteer numbers necessitates a "limited outreach". When a visit is made, usually two will go, reporting in to their managing director before and after contact.

Parents Anonymous has also worked



with government bodies and community groups to start up child abuse lines in several provinces and has been used as a necessary component in child sexual abuse therapy in the United States.

Most chapters of Parents Anonymous have a "speakers' bureau". Speakers from the H/W/B/O chapter, for example, talk to social clubs, schools and community organizations. They find most children know they should contact the police if they have been abused. The

## ***Ironically parents who need help rarely seek it.***

public, on the other hand, often needs to be informed that those involved with Parents Anonymous have not necessarily physically and/or sexually abused their children. Many of these parents are just concerned about their potential to hurt their children through emotional abuse, deprivation, or verbal assault. Parents who have physically abused their children are a minority in Parents Anonymous, frequently referred by the Children's Aid Society. Ironically these parents, who desperately need help, rarely seek it unless they are forced to.

Financially, the Canadian headquarters of Parents Anonymous is doing better than some chapters because, along with private donations, partial funding by the United Way and various fund-raising sources, the H/W/B/O chapter receives municipal grants.

The Toronto chapter could use more money, but its most immediate need is for volunteers. While its 24-hour "hot line" continues to function, few speakers are sent out any more, and of the two discussion groups within this region one has not met in nearly a year.

The reasons are varied: many parents are not able to come out to meetings because of transportation or babysitting problems, and some parents do not immediately see the value of group interaction. But the core of the problem seems to be a "burn-out" of volunteers. It's difficult to keep them, especially through the summer, and even harder to recruit new ones.


Admittedly lacking in leadership and direction, the Toronto members are in limbo, but are confident the state is temporary; more meetings are planned and there is talk of a proposal to the Ministry of Community and Social Services for a co-

ordinator, if only part-time.

Meanwhile, a name change in the works could bring more people out to Parents Anonymous meetings in the future. Early this year the National Headquarters of Parents Anonymous in Canada adopted the new name "Parental Stress Services", reasoning that the latter would be "less threatening". Parents Anonymous "carries the stigma of child abuse", says national's secretary Barbara Carey. "The new name seems to have more acceptance in the community; a public health nurse is less hesitant in suggesting us to needy parents now."

The name change is not well known yet because it has not been adopted by all member groups, although National Office hopes they will all eventually follow suit.

Whatever the name, the goal remains the same: to help prevent damaging relationships between parents and their children. For more information contact a chapter in your area.



# **MADNESS NETWORK NEWS**

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# Psychiatry &

# Report on Kids

# Kids & Psychiatry

**A SPECIAL REPORT**

## ON THE TREATMENT OF TROUBLED CHILDREN

In May of this year, a 15-year old British Columbia girl named Katrina Cummings jumped to her death. It was her eighth suicide attempt within a year.

Katrina was only one of a growing number of children and young people who kill themselves each year in Canada. In 1977 (the most recent year for which *Phoenix Rising* has statistics), in Saskatchewan alone four children under the age of 15 committed suicide, as did about twenty-four young people between 15 and 19. Across Canada that year, about 50 girls/women and 150 boys/men under the age of 24 killed themselves, including five children under ten years old and this doesn't even take into account the number of suicides listed as accidents. Suicide rates among young people increased four to five times between 1971 and 1977, and have continued to increase over the last four years.

Suicide is the most dramatic evidence of the fact that children and adolescents in Canada often face serious and crippling emotional problems. One study indicates that 2% of Canadians under 18 have emotional disorders, and a further 3% are learning-disabled. Together these figures include about 350,000 children; emotional disorders alone account for over 140,000.

Yet across Canada government services to these young people are woefully inadequate, often of inferior quality, and plagued with a host of jurisdictional problems. With the sole exception of Quebec, control over children's "mental health" is split between or among two or three different ministries, bearing names such as "Health", "Social Services", "Human Resources" and "Corrections". Very often the government's right hand doesn't know what its left hand is doing; co-ordination among var-

ious ministries and agencies hardly exists.

"There are very limited resources for children. Most troubled kids just hang around or end up in juvenile court. There are not enough group homes. In Fredericton there is only one group home and that's for boys."

--Dr. John Swaine, clinical psychologist with the Child Guidance Centre in Halifax

The first problem facing a child with difficulties is having someone recognize there *are* difficulties. Take some Saskatchewan figures for example. A 1980 government report says that the estimated number of young people under 20 in the province who are emotionally disturbed is 6,941; of these, 150 have been identified by their schools. Of an estimated 10,422 learning disabled, 621 have been so identified. (These figures exclude the small number of children in institutional programs.)

A young child, unlike an adult, is not usually in a position to look for help himself or herself; someone must do it for him or her. Parents or foster parents may not recognize the problem--and in some cases parents *are* the problem. Child abuse--physical, emotional and sexual--is among the causes of emotional problems in children, and it is certainly unrealistic to expect an abusing parent or foster parent to seek help for the child in dealing with the abuse. Some provinces have registry systems for keeping track of child abuse cases. However, there is still a great reluctance on the part of friends and neighbours to "get involved" by reporting abuse, and the registries are far from complete. They are also often in-

efficient. In Alberta, for example, according to Ombudsman Dr. Randall Ivany, the registry is set up in such a way it is very easy to check the names of abused children, but very hard to check those of abusing adults. This has resulted in several cases in which children have been placed in the care of parents or foster parents with a record of child abuse, and have suffered severely--even died--as a consequence.

Older children are in a better position to call attention to their own problems and seek help for them. But few do. A recent Toronto study found, for example, that only 17% of abused children had complained about the abuse. and this was in a community with many well-publicized youth services such as crisis lines and counselling services. Most of the country has no such resources; the entire province of Saskatchewan, for example, boasts a total of six child psychiatrists.

"Certainly since our crisis unit got started (eight years ago) we're seeing more kids and younger kids. We've seen an increase in young suicide. There's a great degree of depression in young kids--there's a lot of acting out behaviour, agitation, concentration problems. We see kids who have been physically abused, sexually abused. Kids who commit suicide are vulnerable to begin with and don't have the resources to deal with their problems. There aren't enough services. Case-workers are swamped. And it's hard for kids to get the message across to say they need help."

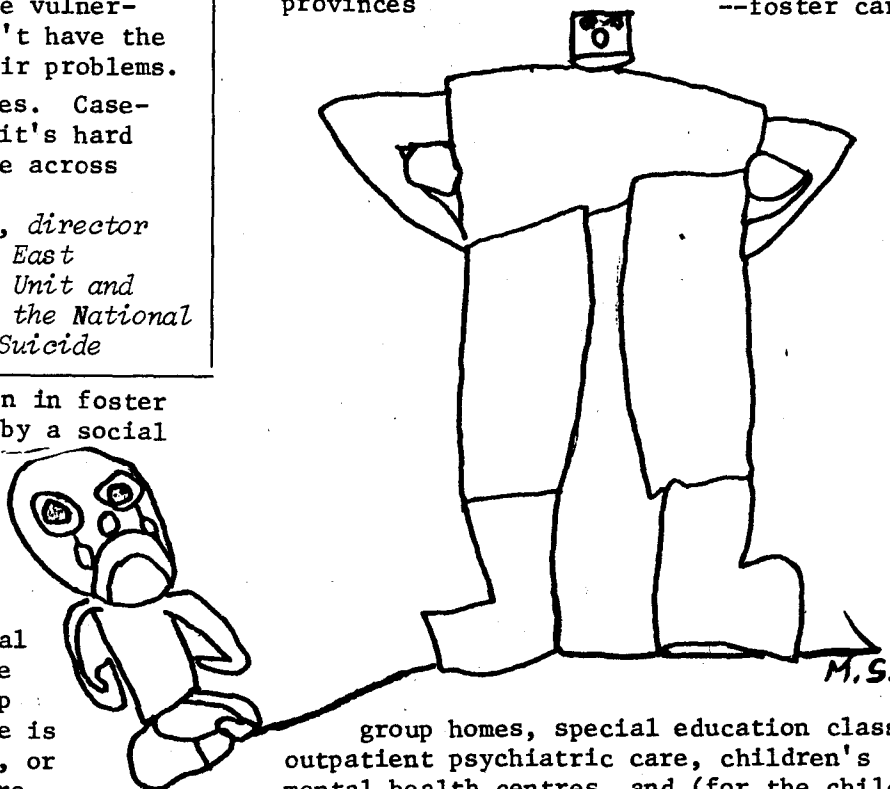
--Dr. Diane Syer, director  
of the Toronto East  
General Crisis Unit and  
chairperson of the National  
Task Force of Suicide

In the case of children in foster homes or under supervision by a social agency such as the local Children's Aid Society, a trained social worker is supervising the care of the child. One would expect such a worker to recognize a child's emotional difficulties and to be aware of resources that could help them. In fact, the evidence is that workers often discount, or do not recognize, even severe physical abuse. Dr. Randall

Ivany's report on the Alberta situation relates, for example, that a home continued to be rated satisfactory by workers after a foster child was shot to death by the family's natural son, who had been known for several months to have emotional and drug problems. A nine-year-old boy died in a second home of massive brain damage after the last of several beatings with a belt. Although workers are supposed to visit homes at least once a month, 18 months may elapse between visits. Given this situation, it is no wonder that emotional difficulties often go undetected by the agencies charged with the care of the child.

Even good and well-meaning parents or foster parents may not recognize signs of trouble. Disturbed behaviour may be seen as "stubborn" or "lazy", or simply as something the child will outgrow--a "phase" the child is passing through. And, as indicated by the Saskatchewan figures already given, schools may react in the same way. No one may recognize the problem until it has grown to serious proportions.

But suppose you are one of the fortunate children whose difficulty is recognized. Where do you, or your parents, turn for help? In theory, there is a wide range of services provided by most provinces --foster care,



group homes, special education classes, outpatient psychiatric care, children's mental health centres, and (for the child whose problems have led him or her into →



more serious behaviour difficulties) the juvenile court system, with its own observation and detention homes, correctional group homes and training schools.

Let's examine these alternatives one at a time. Alberta's foster care system has already been mentioned, and its shortcomings are not unique. Foster parents in too many cases are in it for the money rather than for the good of the children, and agencies often use poor and untrained foster parents as a cheap way of providing child care. "Difficult" children--the ones most in need of love and stability--frequently get moved from home to home at two to three month intervals because the foster parents find them hard to deal with. Different agencies may provide different amounts of payment to foster parents, setting up preference for particular agencies. Insufficient money, information and support are made available to even the best foster parent to enable them to do a proper job. And, of course, most foster parents have no special skill or training in dealing with disturbed children. Foster care becomes a way-station along the road to institutionalization.

Group homes are another alternative for the child who can not or should not deal with his or her problems at home. They are often hard to find, and suffer early when budgets are cut. One such home for disturbed children, for example, has just closed in Oakville, Ontario, three weeks after a study reporting a shortage of such facilities in the region. About 115 children a year must be placed outside the region because of the shortage. Reports abound of children needing group home care who face waiting periods of months or even years, and meanwhile are warehoused in psychiatric hospitals, juvenile detention centres, or even adult jails.



And group homes are not immune from the problem of child abuse--sometimes disguised as therapy. In an earlier issue of *Phoenix Rising* we reported on one Alberta

home where, under the direction of a psychologist, a young boy was forced to eat dog food laced with Tobasco sauce, and an adolescent girl had to smear walls with her menstrual discharge.

"The move to group homes has been disastrous. The staff employed are often undertrained, very young and inexperienced. Acting out kids are very hard to deal with--love is not enough. Eight or 10 of these children are really hard to handle."

--Barbara Chisholm, Child Welfare Consultant

The child who remains at home may be eligible for special education classes at school--if they exist in the area, and if they are not already crammed full. Board of Education cutbacks are frequently reflected in cuts in these special services--cuts in time, cuts in qualified specialist teachers, and the placing of emotionally disturbed children together with mentally handicapped children, who have a quite different set of needs.

Outpatient therapy then, perhaps. This is readily available only in large cities; rural Canada can't afford such luxuries. Remember Saskatchewan and its six child psychiatrists--*all* of whom are in Regina and Saskatoon. Well under half of Saskatchewan's troubled young people received *any* outpatient services in 1978. The rate for native Canadian young people in the province was much lower yet. ➔

"I think this is why you get the higher visibility for the adolescent problems now--because we had a fairly good series of services and they've been cut back. I'm not mincing words--I think that's what has happened.

We used to have alternatives to whom we could direct cases that appear an emergency if we haven't a bed available which happens all too frequently. Now there are no crisis beds available for adolescents. Virtually none. And some of our staff spend a lot of time looking for alternatives."

--Dr. Quentin-Rae-Grant, Vice-Chairman of the Department of Psychiatry at the University of Toronto and Chairman of the division of Child Psychiatry (Psychiatrist-in-chief) at the Sick Children's Hospital

# G.P.s guilty of overdrugging kids

While researching this issue on children and psychiatry, *Phoenix Rising* discovered very few institutions and group home facilities have a set policy on giving drugs. Most rely on the discretion of the physicians on staff or on the doctors of the children in their care.

Because none of the provinces in Canada keep records on the prescription use of their citizens, other than Saskatchewan, we were unable to statistically document any trends we believe exist. The professional literature and the discussions we had with professionals and child care workers seems to bear out our suspicion that the drug prescribing patterns in Saskatchewan apply to most areas in Canada.

Statistics in Saskatchewan for 1977 reveal a trend towards the use of more drugs on boys and girls up to the age of nine. Boys were given stimulants (such as Ritalin) in a more than five to one ratio to girls, while antidepressants were given to boys close to one and a half times more than to girls. Minor tranquillizers (such as Valium) were given at a rate of a few percentage points higher for boys than girls. These drugs prescribing patterns reversed themselves on children 10 years and up.

Most of the people we talked to felt that while drugging and misuse of drugs still occurs, those who work closely with children are more careful about drug use than they were ten years ago, largely due to public education programs about this problem. Many told us that the present-day culprits of over-drugging and the misuse of drugs are general practitioners.

One child care worker, who has been in the child care field for several years now, applied for and was hired for a supervisory position in an institution where the practice of over-drugging went on.

*"I was interested in teaching staff and that was the attraction for me to take this job. Then I found out that I was going to have to give out medication--there was no house doctor or nurse on staff. I know a fair bit about drugs but I have no formal medical training so I was kind of upset to find out that I had to give out drugs."*

*"The parents ordered drugs from doctors--there was a general practice clinic around the corner from this institution. Because the drugs were all coming from different prescriptions from different doctors all over the place there was really no one to go to and say 'Listen, I really don't think I should be giving 5,000 milligrams...'"*



The same child care worker worked in a summer camp last year where one 10 year old high functioning autistic child was on 175 milligrams of mellaril a day: I said to the parents, *"That's an awfully high dosage,"* You can't really say anything more than that. *"Maybe you should talk to your doctor about what he thinks about reducing the medication."* The doctor said, *"Oh, so you want him off the pills, we'll take him off the pills."* Cold turkey. That child a year later is still hitting himself in the head. It was a total and absolute behaviour change."

Dr. Quentin Rae-Grant, chairman of the division of Child Psychiatry at Sick Children's Hospital in Toronto, told us his staff "not infrequently" runs into children who have been over-prescribed.

*"The people who tend to over-use the drugs are those who know the least about them. Ritalin is prescribed much more by family practitioners and by some pediatricians than it is by people who work really intensively with kids."*

Several professionals we talked to told us the practice of over-using drugs on children is more acute in the country where there are fewer services for children with problems and practitioners don't have the opportunity to share information and new ideas with other doctors.

For the child who has not found any of these resources, or who has been exposed to their darker side, two alternatives remain: inpatient psychiatric care, and the correctional system.

In 1979, almost 25,000 children appeared in juvenile court, charged with offences ranging from serious crimes to merely annoying behaviour, such as skipping school. Juvenile court is meant to be an environment which is concerned, not with *punishing* children, but with *helping* them. To this end, as Jeffery Wilson points out in his "*rights and wrongs*" article (pg.19A), the court has almost unlimited power to make decisions "in the best interests of the child". The court is also not bound by the strict standards of proof which prevail in adult court. In theory, a child could be indefinitely committed to a training school or other institution without its ever having been shown beyond a reasonable doubt that he or she actually committed the offence charged; the decision could well be made on hearsay and other types of evidence unacceptable in an adult court. And even if the child *has* actually committed the offence in question,

"In detention, the window's caged--like, it's the kind of window you can't see through. They have a little mattress but if you're bad, they take it away from you. In Lindsay, the detention cells are a lot better than in Calt. Lindsay at least is painted--a real sick green--it's got them funny polka-dotted floors and it's got a fair-sized window. But in Calt, like Churchill House, the whole place is all grey brick with big iron doors and big brass keys. They lock you in your room every night and your room is about 8' X 8', if that. It's got a sink and a toilet and a little skinny bed. No one goes in your room but there's a window on your door. It's got a sort of a cage on it. Like, I mean, if they lock you in one of those rooms, there's no way you'd ever get out of there. That's got to be the sick-est place on earth."

--Diane: (16, about one year in Lindsay and Galt 1974-75) from "*We still Lock Up Our Children*" (Toronto Life, May 1976) by Don Weitz

and is thus liable to be found to be "delinquent", the gravity of the offence may be irrelevant. Once a child is found "delinquent", the court may send him or her virtually anywhere for virtually any length of time.

"The mental health of children pre-dates society's investment at crunch stress times. They are nowhere near good enough services to offer help to young families. An unhealthy family is a contagion force, but we're trapped in a dogma of self-determination."

--Barbara Chisholm, Child Welfare Consultant

Of the 25,000 children a year who appear in court, 18,000 are labelled "delinquent" and disposed of in various ways, ranging from reprimands to probation to fines or restitution. But from 1,000 to 2,000 of these children are sent each year to "training schools". Neither the children nor the rest of society are deceived by the name; training schools are jails. They are the last resort of a system which has been unable to help its young people, and can think of nothing else to try except locking them up.

About twice as many boys as girls are sent to training school. (Curiously, in Ontario the ratio is nearer 4 to 1.) This is probably a result of societal mores, in which, first, boys are more likely to demonstrate disturbance by violent antisocial behaviour and *machismo* than are girls, and second, girls who *do* demonstrate aggressiveness are more likely to be punished for it than are boys. A sexual double standard applies to offset this, girls can be sent to training school for "promiscuity", while this is unheard of in the case of boys.

What happens to girls and boys when they arrive at a training school? Let's take a look at a recent Ontario government document titled "Secure Services Paper: A Public Policy Statement" (January 1981). The paper deals with Ontario training schools and secure detention centres for children awaiting a court hearing, along with secure psychiatric facilities (which will be discussed below). Within *all* these facilities, secure "isolation rooms"--in other words, solitary confinement cells--will be provided as a matter of policy for

children who *might* cause harm to themselves, to others, and/or to property.

Children will be able to be locked up in these rooms for as much as twelve hours a day to a maximum of thirty-six hours a week, and for longer with advance approval.

There are many psychological studies in Canada and the United States which conclusively show that, in children and adults alike, prolonged isolation frequently causes hallucinations and other psychotic symptoms within twenty-four to forty-eight hours. Solitary confinement should have been abolished years ago--but the Ontario government still sees it as an acceptable way of handling troublesome children.

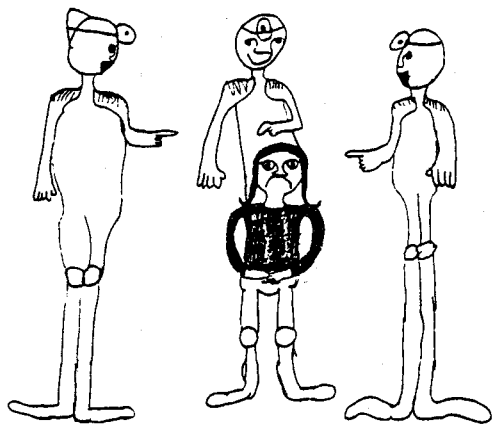
The report goes to great lengths to assure us that adequate legal protection and information will be given to children admitted to "secure units", including training schools. However, it is conspicuously silent on just what rights the child has while locked up, and what sort of program or treatment awaits the disturbed young person. Perhaps a good dose of behaviour modification of the sort administered in the Alberta group home described earlier? Perhaps forcible drugging with Ritalin or chlorpromazine to control "hyperactivity" or "psychotic" behaviour? Given the horror stories coming out of institutions which are not meant to be punitive, such as group and foster homes for children who have committed *no* offence, one can only assume that the "difficult" and dangerous children in our training schools may often be subjected to even worse.



Over the last three years, as the result of a Supreme Court of Canada decision, a new wrinkle has been added to the juvenile corrections system. It used to be that when you were sixteen years old, any juvenile record was closed. If (as happened all too often) you continued to have difficulties with the law and found yourself in adult court, the fact that you had been in a training school could not be mentioned in court. You were treated as a first offender. This is no longer the case. In other words, it is entirely possible in our system for a child to, first, have to appear in juvenile court for something that would not be a crime if done by an adult (such as truancy); to be found guilty of that offence on less evidence than it would take to convict an adult; to be sentenced to any term which appeals to the judge in a training school; and then to have the whole episode brought out in adult court at a later date as proof of the child's "delinquency", and with the probable effect of increasing his or her sentence.

And we must bear in mind at all times that we are talking about *children*. In a speech he made in June, Peel Regional Family Court Judge Warren Durham, who deals with these children daily, reminded his audience:

These kids who end up in the court are good kids, not bad, but unbelievable things have happened to them. They were abused, adopted at a late age, went through multi-marriages or relationships, were rejected or had alcoholism in the family. ... Nothing in the social service system has worked. We have more violent crimes, more anger, frustration, and they're coming in greater numbers.



Christine Hurrell



Some children with severe problems are fortunate enough to have them discovered before they lead to behaviour of sufficient seriousness to land them in juvenile court, with the probable resulting stigma of "delinquency". A number of these children--about 6,000 a year between the ages of 0 and 19--end up undergoing psychiatric care in one of Canada's mental health facilities.

Many do not. In the last year or two, newspapers have reported cases in which children desperately needing intensive help have ended up, because of lack of resources, in adult psychiatric wards totally unsuited to their needs, or even in adult jails. Waiting lists for this sort of care are months or years long in some parts of Canada. Poor as our adult psychiatric facilities are, we don't make adults wait for a year to be admitted; if they are in crisis, there is a place ready to take them in. This doesn't apply to children.

True, access to specialized children's mental health facilities is increasing; between 1971 and 1978, admissions to treatment centres for emotionally disturbed children in Canada roughly doubled, from 1304 to 2505. (The remainder of the about 6,000 admissions are to other types of institutions.) But this comes nowhere near meeting the demand. For example, in April 1980, forty-nine Ontario children's mental health centres (of an Ontario

total of about seventy-five) reported that they had 1,700 children on their waiting lists, some of whom would have to wait up to a year for service.

These institutions offer many kinds of programs to troubled young people--milieu therapy, group therapy, medication, psycho-therapy, everything one could think of. The irony is that, at least with the more violent and disturbed child, none of it works. All the brave new ideas and high hopes for a fresh approach to helping our children have proved to be illusory. Last September,

"The most significantly troubled kids are adolescents--victims of the permissive society. Children are being robbed of their childhoods. They must be self-determining. The permissive society is an excuse for parents who don't want to stick with the long haul of parenting."

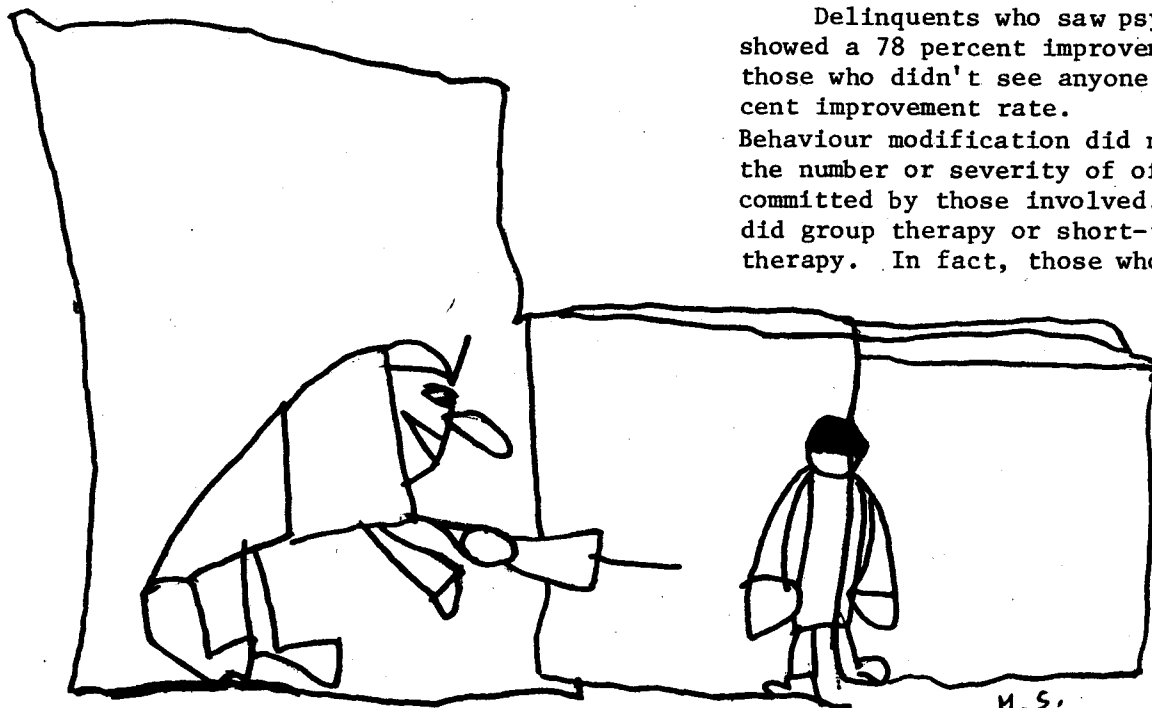
--Barbara Chisholm, *Child Welfare Consultant*

Dr. Jalal Shamsie, Director of Research and Education at Thistletown Regional Centre for Children and Adolescents just outside Toronto (see accompanying story) presented a review of 120 studies in the field. His conclusions?

Group counselling over a period of 18 months produced adolescents who had worse discipline problems and police records than those who hadn't seen anyone.

Delinquents who saw psychotherapists showed a 78 percent improvement rate; but those who didn't see anyone had a 72 percent improvement rate.

Behaviour modification did not affect the number or severity of offences committed by those involved. Neither did group therapy or short-term family therapy. In fact, those who got lon-



ger term family therapy had more behavioural outbursts.

Milieu therapy failed to reduce the offence rate. Of four studies on the "therapeutic community" approach, three showed no effect and one showed a negative effect.

Dr. Shamsie summed up:

*One would be shocked if general practitioners continued to prescribe a medicine, year after year, which had been proved to be ineffective; yet in children's mental health we continue to use techniques which have repeatedly been shown to be ineffective.*

What, then, is left? We spend millions of dollars and an unbelievable amount of time and effort shunting children around the system, moving them from foster home to group home, from psychiatric institution to training school, getting them on waiting lists and into special classes, trying to find the right hole to fit our difficult peg into. Any now we're told that it's all a waste of time, that none of it works, and we might as well have saved our energy.

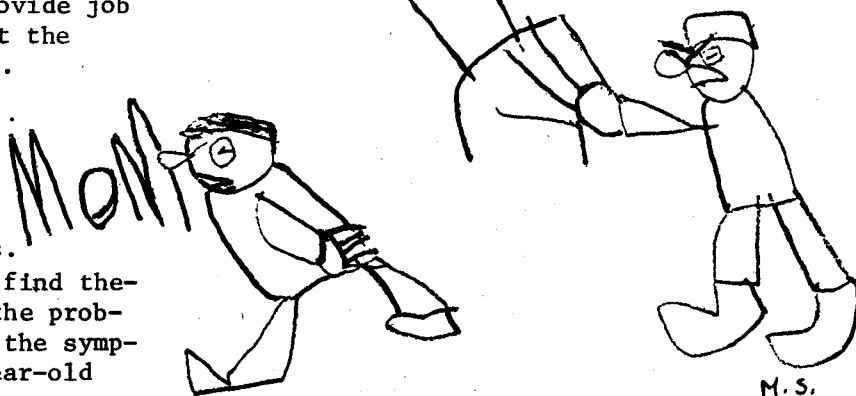
What's left, and what may be our only hope, is *prevention*. The one cheering note in Dr. Shamsie's gloomy report of our failures was his discussion of an experimental program in Boston. Adolescents in the program were trained for jobs. When they lost jobs, they were shown why it had happened. They were given tips for getting ahead. In general, these young people settled down, married, had families and stayed out of trouble with the law.

We probably don't want to provide job training for three-year-olds. But the principle is the same at all ages. Most of our disturbed children have something disturbing them--an impossible family situation, economic difficulties, troubles at school, and so on--real pressing problems. We need a system in which we can find these children early and deal with the problems themselves rather than with the symptoms. As one disillusioned 16-year-old put it:

*"All my life, since I was 9, The Children's Aid, probation officers, all kinds of social workers and psychologists have been trying to find out what's wrong with me: Shit, it wasn't what was wrong with me. It was what was wrong with my old man. The jerk's a drunk. He's the one who booted the hell out of me and threw me out of the house when he was pissed. And everybody wanted to know what was wrong with me."*

We need to identify these problems early, before they have warped young minds, rather than trying to straighten out the minds later. We need to be aware of child abuse, both physical and emotional, of emotional deprivation, of malnutrition and poverty and prejudice.

We need people who can intervene where these problems arise and counteract their effects. These people need to be skilled and loving professionals, not the untrained and underpaid staff we find in many of our present institutions and other resources. And, perhaps most important, we must find ways of intervening that interfere as little as possible with the good things in the child's life. Rather than officiously removing a child from a family where, in spite of real problems, he or she is loved, and moving him or her around like a game of musical chairs, we have to help the family deal with the problem. Rather than setting up special institutions, except in the direst cases, we have to integrate all the help we can →





give into the child's own community and school. We must provide support to harried single parents so that they can spend time with their children, and see that recreational programs, summer camps and other valuable experiences are available to *all* children as a matter of right, not just when charities manage to raise enough money from donations to provide them.

In short, we have to change our society. One day our children will *be* our society. And unless we value our future enough to put the needs of our children high on our list of priorities, that future will be filled with violent and angry people who are the result of our neglect and our failure.

"It's very difficult to talk about prevention. It can sometimes be used as an alternative for providing treatment. You have to do the two things simultaneously. It's sometimes sold as if only people lived healthier lives, then there'd be a reduction in the cost of medical care. That's not true because it would mean the population would age, and the more the population, the more the medical costs. I'm all for prevention, but prevention can be a bit of a political football and can be used to justify not doing what needs to be done today while looking ahead 10 and 20 years down the line. You'll see the change working with an abused child a lot further down the line than most politicians seem to think."

--Dr. Quentin Rae-Grant, Vice-Chairman of the Department of Psychiatry at the University of Toronto and Chairman of the division of Child Psychiatry (Psychiatrist-in-chief) at the Sick Children's Hospital

# Thistletown - then and now

The evolution of treatment methods for troubled and "anti-social" children in Canada is perhaps best reflected in the development of Thistletown Regional Centre, one of Canada's first residential treatment centres for children.

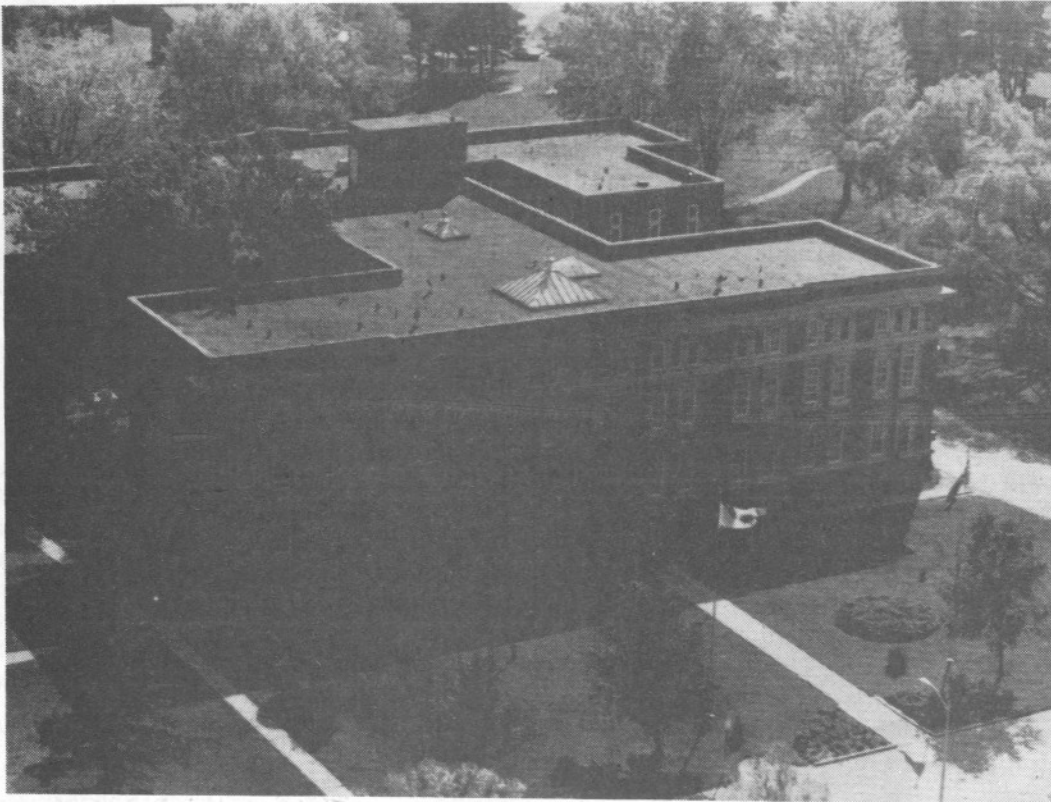
Located on the outskirts of Toronto in a building that had once been a convalescent hospital for children, Thistletown opened its doors in 1957, at a time when children from the baby boom period were beginning to grow up.

Thistletown pioneered and developed the concept of training students to deal with troubled children by paying them to learn by working on the premises with children. At that time, few people had any experience in working with disturbed children in a residential setting.

By the early sixties, two import-

ant changes had taken place. One was the development of community colleges, which took over much of Thistletown's teaching role by giving budding child care workers theoretical training before sending them into the field for practical experience.

The other was Thistletown's move away from the model of keeping children institutionalized for long periods of time with little contact with their parents, and toward a greater emphasis on out-patient treatment. During the sixties, Thistletown developed programs involving home care, day care, and foster parents, and instituted prevention programs that reached out into the community in North Etobicoke from which large numbers of children were being referred to them. Of course, it was not possible to deal



The Thistletown Regional Centre opened in 1957 as one of Canada's first residential treatment centres for children in a building that had once been a children's convalescent hospital. The T.R.C. pioneered student on the job training concepts which laid the foundation for more recent community college training techniques. At left is the original building. Smaller group home cottages were added at a later date.

with *all* children as out-patients, and the institutional model could not be completely abandoned.

In the late sixties, John Brown of Warrendale revolutionized the treatment of children, including Thistletown's approach, by suggesting that, when a child had to be removed from his or her home for treatment, it might be more productive to place the child in a small surrogate family unit rather than in an institutional setting.

Brown, in an essay written fourteen years later on the occasion of Thistletown's twentieth anniversary, remembered:

*"I found the child welfare field unorganized, rife with a strange mixture of pseudo-professionalism and punitiveness. Children with problems were generally unwelcome ... diagnostic services for children were extremely poor and direct services were even poorer. Drugs, shock and knock-out shots, detention and isolation were the order of the day. Talk was the method through the shield of objectivity. Children with problems were driven into great loneliness and isolation. No one offered love.*

*By this time the famous "children's pipeline" was in full function within the "children's services mafia". This is a system that still exists where professionals in the various establishment services pass children back and forth to one another, confirming and affirming the untreatability of the child within a closed system that is stacked against the kid and designed to protect the professional.*

*Children were transferred from place to place until they automatically stopped presenting problems, but more often they ended up in the retardation institutions run by the Ontario Department of Health or the training schools where they were rejected or "disciplined" in every manner imaginable for moving out of line or showing defiance."*

What could be more natural, reasoned Brown, than the family as a treatment unit? He and his co-workers worked intensively with kids no one else would deal with. Although Brown has been criticized for some of his activities in the child care field since that time, there is no doubt he had a tremendous influence on child care treat- ➔



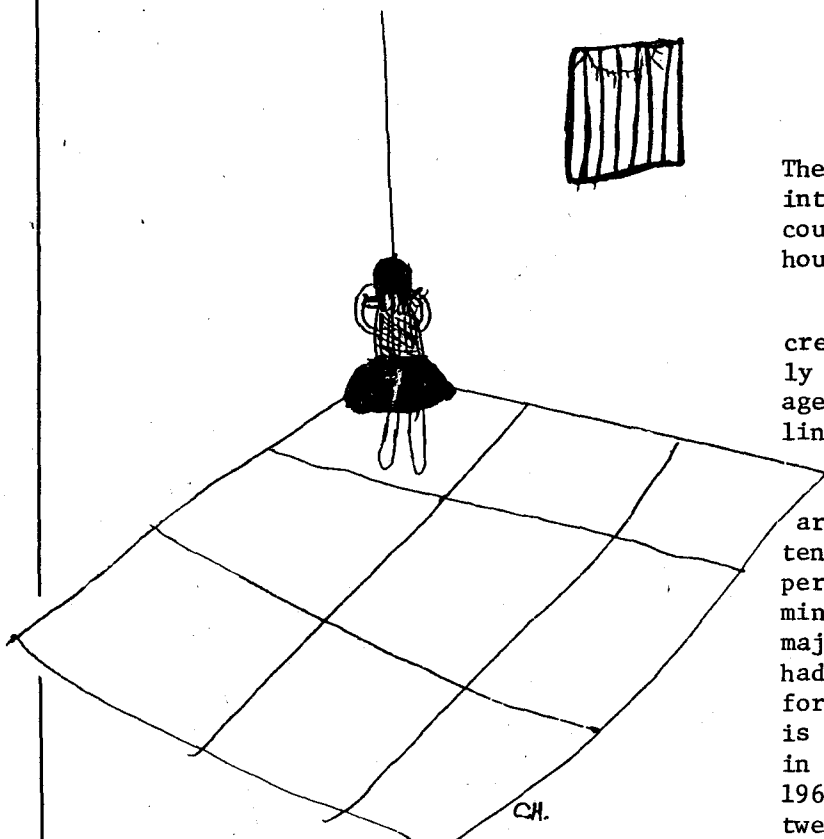
ment, and was largely responsible for popularizing the idea of group homes.

During this period, Thistletown took over Warrendale in a messy struggle for power with Brown and his loyal co-workers; Brown and his allies finally left and founded Browndale Homes. Thistletown then made the takeover complete by building several homes on the property and transferring into them a number of children who were living in the main building. A child worker who was at Thistletown during this period describes the atmosphere at the time as "chaotic".

*"When we were in the main building, kids were locked in four wards. Just to go to the bathroom they were locked in. There was no sense of freedom at all...some of the kids had been there four or five years.*

*And we took these kids and put them in \$90,000 homes!*

*The main problem was that kids used to being locked up were given a nice, clean house, a decent bed, and the freedom to come and go. And they blew sky high."*



Houses were designed for specific kinds of therapy; this worker was assigned to one containing only boys (the only sex-segregated house) who were undergoing behaviour modification. Each house had eight to ten children, and was supposed to have thirteen staff, including a social worker, a teacher, a psychologist, a physio-therapist, child workers and students. However, scheduling was poorly managed, so that at times there were far too many staff on a shift and sometimes not nearly enough. "The students kept countermanding each other," she remembers, "so the kids got to the point where they totally tuned out--and who could blame them?"

The lack of consistency in approach created an atmosphere in which it was difficult to air problems staff members had in working with the boys. This worker was raped by one of the residents whom she had gone out of her way to help, and she felt she had no one to turn to and discuss it with. "It took me years to get over the incident," she says. "I'm still uncomfortable around men."

At this point in Thistletown's history, use of drugs was already becoming fairly standard. According to the same worker,

*"there was a lot of cases of unnecessary drugging. We (the child care workers) weren't supposed to give out drugs, so we didn't know what was being given."*

There was also a "quiet room"--a padded cell into which a child who was "acting out" could be put for twelve to twenty-four hours until he or she "calmed down".

Since that time, drug use has increased at Thistletown. The centre generally avoids using drugs on children below the age of puberty, with the exception of Ritalin, which is occasionally used on "hyper-active" children. However, antidepressants and major and minor tranquillizers are used more frequently than they were ten years ago. In the early sixties, one percent of children discharged were on minor tranquillizers and thirty percent on major tranquillizers; in 1978 those figures had been increased to seventeen percent and forty-seven percent respectively. This is at least partially explained by a shift in the age of Thistletown's residents: in 1960 and 1961, only three percent were between 13 and 18 years old, while in 1978

sixty-one percent fell into that range.

Rick (not his real name) is one of the young people who received these drugs during his year and a half at Thistletown in the late seventies. He was fifteen when he went to Thistletown.

Rick began to have problems at the age of twelve or thirteen. His teachers kept telling his mother that he was disrupting classes and not doing his work. His mother tried to get him admitted to Craigwood, a special school for troubled children in London, Ontario, but while they were waiting, Rick missed eleven months of school. He was finally admitted, but ran away several months later. The Craigwood teachers told Rick's mother that Thistletown was "The only place" for him.

Rick was admitted to Thistletown in November 1978, with a request from his mother that he not be given medication. And during his first three or four months, he was not. He seemed to be improving, and was allowed to come home every week or two. He still had "spells"—brief periods of staring blankly or throwing things—but he never hurt anybody. And he always returned to Thistletown willingly after his home visits.

Some time in the spring of 1979, in spite of his mother's request, the staff began to give Rick drugs "to control him". Rick reacted "like a caged animal". He often tried to refuse the medication, but it was forcibly injected, as much as 800 to 1600 mg of chlorpromazine a day. Since Rick was big and strong for his age it took two or three staff to hold him down while he was given the needles.

While his mother visited him, she found him "completely helpless. He couldn't think; he couldn't talk. He was at the mercy of others." A staff psychiatrist and a nurse kept telling her Rick "needed" the high dosage.

She refused to accept the explanations, and tried to persuade the staff to lower the dosage. She made numerous phone calls to staff. On one occasion, the psychiatrist said in what

she describes as an arrogant and self-righteous manner, "I'm a doctor, and I know how much to prescribe."

Both the heavy medication and the mother's phone calls continued for months. By this time, his mother was seriously worried, not only about Rick's health, but about whether his life was being endangered. She wanted to speak to her son for a moment or two each day just to assure herself that he was still alive.

On many occasions, staff refused to let her talk to him.

*"He was so heavily medicated. They'd get him up for his meals, then he'd go right back to sleep. I was sure one of these days he would choke to death. I wanted to be sure he was alive, so they wouldn't tell me a few days later that he'd died."*



Annegret Lamure

By the end of 1979 in his mother's opinion, Rick was languishing, helpless and lethargic, in an institution supposedly established to provide humane care and

treatment. On one occasion he tried to run away by jumping out of a second floor window; he escaped injury except for a strained or broken toe.

Early in 1980, Rick's mother lodged a complaint about his treatment with the Children's Division of the Ministry of Community and Social Services. She wanted them to investigate Rick's drugging. She spoke to an assistant of Judge George Thomson, Executive Director of the Division and detailed her concerns. Two or three weeks later the Ministry conducted a token investigation; nothing changed right away.

However, shortly thereafter Rick's dosage was suddenly lowered to 200 to 300 mg of chlorpromazine a day, plus 100 mg of Elavil, and he was reluctantly allowed a few weekend home visits.

There were further incidents of friction between Rick's mother and the Thistletown staff. These came to a head →

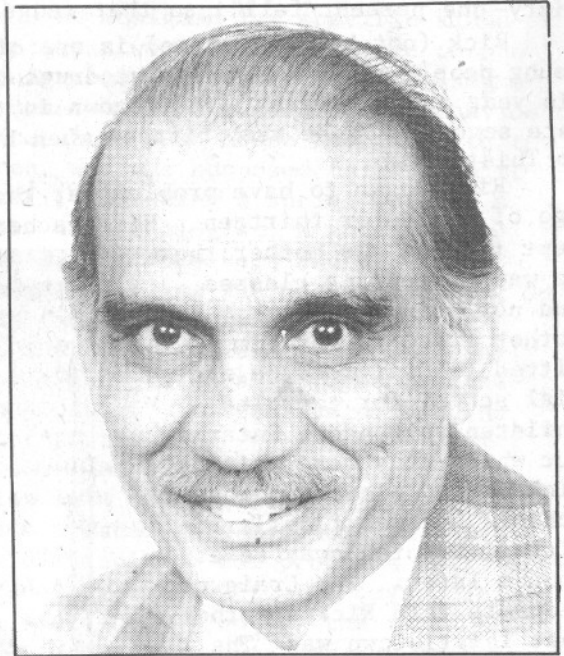
early in 1980 when she was informed that the staff considered Rick to be a "child in need of protection" under the Child Welfare Act, and had called in the Children's Aid Society. A court hearing resulted, but the staff's complaints about her were dropped for lack of evidence.

Rick was finally released in April 1980, and is now in a Toronto alternative school, though still having problems. He's not seeing a psychiatrist, and not taking any psychiatric drugs. But his mother is still angry about his experience at Thistletown. *"They shouldn't be able to give so much medication,"* she says. *"Who's going to stop them?"*

\* \* \*

Thistletown is presently going through another shakeup at both management and program levels. There used to be an administrator and a medical director in charge; in the past year and a half one senior director and five other directors of different aspects of the program have joined the staff.

The program changes are being influenced by a paper presented by Dr. Jalal Shamsie, the Centre's Director of Research and Programs, last year, which found that most treatment programs used with adolescents had no substantial effect on anti-



Dr. S. Jalal Shamsie

social behaviour (see main article).

We've got to be very innovative to find out what is going to help them," says Shamsie. "Following gut feelings is not a good approach; we should be scientific about this. Theoretically and emotionally I was committed to the therapeutic community—but if it doesn't work, it doesn't work."

Because of the results of the study

continued on page 16

## Norma Dean—a tragedy

On August 20, 1976, 14-year-old Norma Dean killed herself in Ontario's Kawartha Lakes Training School.

Norma had been an inmate for four months at the Thistletown Regional Centre for disturbed children. Staff at Thistletown had a policy that if one of the children they were treating committed an offence, the child would not be taken to court the first time. However, for every subsequent offence, *the treatment staff themselves* would lay court charges in an effort to teach the child to take responsibility for his or her actions.

Norma had problems at Thistletown—problems severe enough that the staff

had prescribed and administered anti-psychotic drugs to her, and had been subjected to "isolation therapy", or solitary confinement. She was the subject of court charges laid by the staff about twelve times—sometimes for such minor offences as coming in late.

On her last appearance, Norma was sent to the Oakville Regional Assessment Centre with a strong recommendation by the judge that she be placed as soon as possible in a Ministry of Health facility. Instead, Norma was sent to Kawartha Lakes Training School. A few days later, despairing of returning to the institution that had rejected her, Norma Dean hung herself in a closet.

# Quotes from field workers

"I think mental health workers are a very exploited, sometimes deluded category of workers. They are low paid and unorganized. Mostly women work in these jobs. Many of the workers I've worked with are fairly caring people who want to do a good job--that's been my experience throughout my 15 years or working with kids. But with cutbacks you have burn-out and some really tired, overworked people who don't have a lot of work alternatives. They're not able to do real work with their clients.

Social agencies are using more and more contract and part-time workers who have no rights under the labour legislation of most provinces. The flip side of that is that they're mostly hired to be babysitters -- they're not given a whole lot of responsibility and authority.

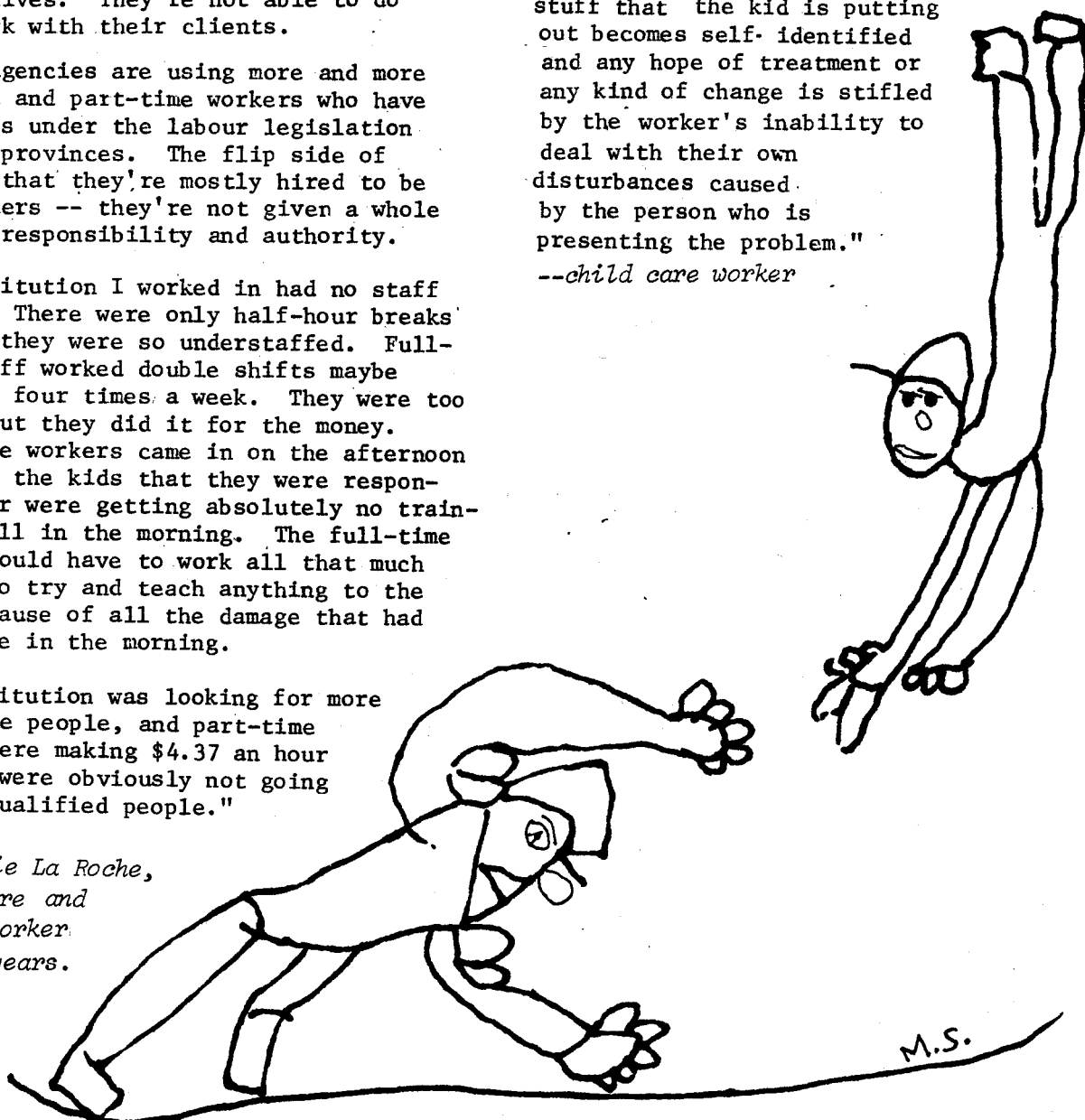
The institution I worked in had no staff lounge. There were only half-hour breaks because they were so understaffed. Full-time staff worked double shifts maybe three or four times a week. They were too tired, but they did it for the money. Full-time workers came in on the afternoon shift so the kids that they were responsible for were getting absolutely no training at all in the morning. The full-time people would have to work all that much harder to try and teach anything to the kids because of all the damage that had been done in the morning.

The institution was looking for more part-time people, and part-time people were making \$4.37 an hour so they were obviously not going to get qualified people."

--Natalie La Roche,  
child care and  
social worker  
for 18 years.

"A lot of people (child care worker students) come from suburbia and don't know what it means to be disturbed or to have a problem. If you asked them what they're doing in child care work their first response would be because they love children--this is a generalization, of course. They don't have an understanding of the process of treatment and what happens when you are working in that kind of situation. So suddenly the stuff that the kid is putting out becomes self-identified and any hope of treatment or any kind of change is stifled by the worker's inability to deal with their own disturbances caused by the person who is presenting the problem."

--child care worker





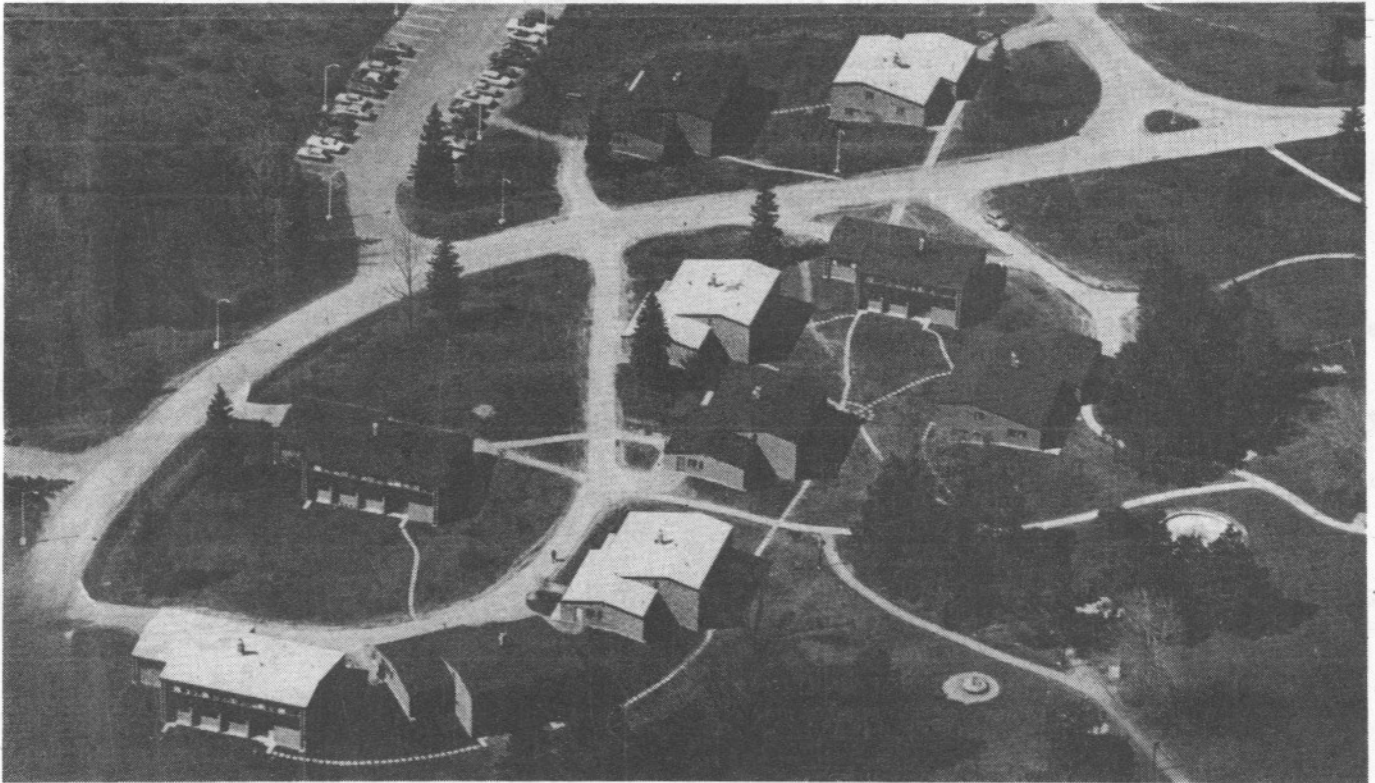
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and other evidence, Thistletown will be pursuing a more work-oriented program with adolescents, along with behaviour modification, peer group pressure and crisis prevention components. The rest of the program will also be changing.

"Up until a year ago we had a highly diversified program," says Dr. Clive Chamberlain, the newly hired director of Thistletown, "each providing an individual type of care. What we're saying now is that comprehensiveness with relatively small parts to them are more effective."

Children will stay in Thistletown less often and for shorter periods of time. "We'll only be using beds when we need beds," says Chamberlain. "We think it's destructive to a child's sense of himself to be living in a hospital. We may have to have staff in the family or we may have to bring the family here. We'll have more day care programs."

It will be another two years until Thistletown programs are established. Only time will tell whether the Centre's new approach will be more successful than the old in helping children cope with their problems.



Aerial view of Thistletown Regional Centre's group home complex.

## The other half- a horror story

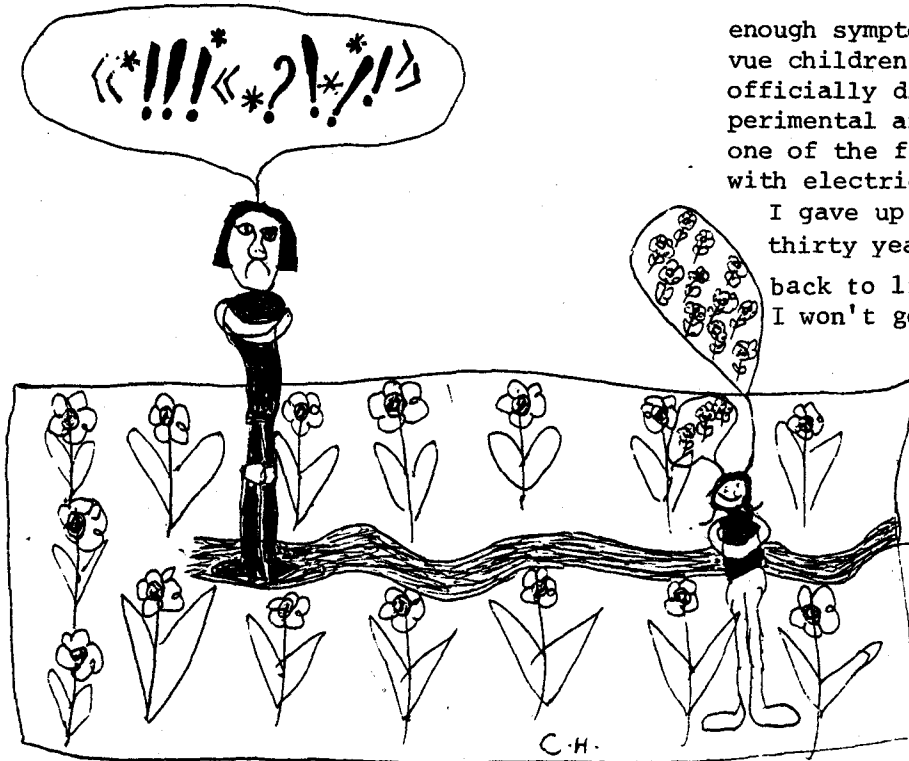
[In 1944, at the age of six, Chabasinski was institutionalized in New York's Bellevue Hospital. He has been active in the movement for psychiatric inmates' rights since 1971. The following article was first printed in *Rising Up Crazy* in 1973 and has appeared in *In a Nutshell*, *Rough Times (State and Mind)*, and *Madness Network News*.]

This is a story about the other half of my life.

Psychiatrists and social workers had

already decided before I was born that I was going to be a mental patient. My natural mother had been locked up just before she gave birth to me and was locked up again soon after. The social worker from the Foundling Hospital told my foster parents, as they put it, that my mother was "peculiar" and Miss Callaghan soon had them looking for symptoms in me, too. Every month Miss Callaghan would come and discuss my "problems" with my foster parents. If I only wanted to stay





enough symptoms, I was sent to the Bellevue children's psychiatric ward, to be officially diagnosed and to be made an experimental animal for Dr. Bender. I was one of the first children to be "treated" with electric shock. I was six years old.

I gave up that little boy for dead thirty years ago, but now he's come

back to life, kicking and struggling. I won't go to shock treatment, I won't!

It took three attendants to hold me. At first Dr. Bender herself threw the switch, but later, when I was no longer an interesting case, my tormentor was different each time. I wanted to die but I didn't really know what death was. I knew that it was something terrible. Maybe I'll be so tired after the next shock treatment I won't get up, I won't ever get up, and I'll be dead.

But I always got up. Some-

thing in me beyond my wishes made me put myself together again. I memorized my name, I taught myself to say my name. Teddy, Teddy, I'm Teddy....I'm here, I'm here, in this room, in the hospital. And →

in the back yard with my sister and make mud pies, this was a sign that I was too passive and withdrawn, and my mommy and daddy were supposed to encourage me to explore the neighbourhood more. When I started to wander around the neighbourhood, I went to a neighbour's garden and picked some flowers. The neighbor complained, and Miss Callaghan held a long session with my parents about curbing my hostile impulses.

I knew that my foster parents were afraid of the Foundling Hospital Lady, but I didn't understand why. Because it was only *me* she could take back to the hospital. "If you're not a good boy, we'll take you back to the hospital where we got you," my mommy and daddy said. But sometimes they would make the hospital sound nice, the place where they picked me out from all the other little boys and girls, though they never explained why they picked me. Three years old, I tried to remember or imagine how it must have been. I was in a crib in the middle of an ocean, thousands of babies like me, all screaming and crying for mothers they didn't have. My mommy and daddy pointed to me and the nurse brought me out, wrapped in a blanket. And they took me home to the Bronx.

When Miss Callaghan had discovered

# To raise kids right, first you have to raise adults.

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my mommy's gone....I would cry and realize how dizzy I was. The world was spinning around and coming back to it hurt too much. I want to go down, I want to go where the shock treatment is sending me, I want to stop fighting and die.

....and something made me live, and to go on living. I had to remember never to let anyone near me again.

I spent my seventh birthday this way, and my eighth and ninth birthdays locked in a seclusion room at Rockland State Hospital. I had learned that the best way to endure this was to sleep as much as possible, and sleeping was all I could do anyway. I was in a constant state of exhaustion, and I began to have colds that lasted all year because the more sadistic attendants would turn off the radiator and open the window, even in December. Dr. Sobel said that it was a sign of my sickness that I didn't like fresh air.

Sometimes the attendants would leave the door to my room unlocked while the rest of the kids went to the dining room. I would roam the hall looking for something to read, something to look at, to play with anything that would make the time pass, anything I could use to keep myself distracted. I would save part of my food and think for hours of when I would eat it. Sometimes mice would run through the room, along the walls, and I would watch them carefully and try not to scare them. I wished that I were small enough to run under the door like they could. Sometimes there was nothing in the room, nothing at all, and I would lie on the mattress and cry. I would try to fall asleep, but I could not sleep twenty-four hours a day, and I couldn't stand the dreams.

I would curl into a ball, clutching my knees, and rock back and forth on the mattress, trying to comfort myself. And I cried and cried, hoping someone would come. I'll be good, I said. And the attendant would stare at me unexpectedly through the little window with wires in it so I couldn't break the glass and kill myself. Every few days, Dr. Clardy would come in surrounded by attendants and tell me that I had to learn to "adjust". "Well adjusted" was a phrase that Dr. Clardy used often. By the age of ten, I had adjusted well to being in solitary confinement.

And so I spent my childhood waking

from nightmare to nightmare in locked rooms with scraps of torn comic books and crusts of bread and my friends the mice, with no one to tell me who I was. And when I was seventeen and the shrinks thought they had destroyed me, they set me free.

*Although this incident occurred almost 40 years ago there are some indications that shock treatment of children may still be happening today. Certainly the attitudes of some professionals have not changed much since then.*

*We would appreciate information and comments from our readers regarding this subject.*



Corporal punishment, says a committee of M.P.'s is just legalized child abuse and should be thrown out of the Canadian criminal code, whether it is committed by parents, teachers, custodians, or a staff member in a reformatory.

*"The proposed change is not to be viewed," the committee says in a wide ranging report by members of all three parties on children's rights and their poverty, "as providing a means of punishing parents, but rather as a step toward protecting children from harm."*

Among the 59 recommendations of the House of Commons Committee Standing on Health, Welfare, and Social Affairs, is the call for the establishment of a federal secretariat of children's affairs, with funding capabilities. The secretariat would monitor services and legislation across Canada that touch on children and serve as an advocacy centre for children's rights.



# Rights and Wrongs

By Jeffery Wilson

I believe mental health has something to do with a sense of self-respect, self-reliance, and the understanding of the way things work about us; and our laws should be designed to encourage these aspects. I also believe, our laws with respect to children are mean and insensitive and, if anything, make children more susceptible to mental illness than to mental health.

We find the word "*committal*" or "*Committed*" in more laws affecting children than affecting any other group in our society. Sadly but predictably, these insidious laws thrive on the pretense that all that is done is in the "best interests of the child". This is a paternalistic, even evangelical notion that presumes that a child, while deserving our care and concern, is nevertheless incompetent. It is that kind of insensitivity that leads children, including some of my clients, to reject their status as "children" and take to the streets with the weapon of a false I.D. and the appearance of adulthood.

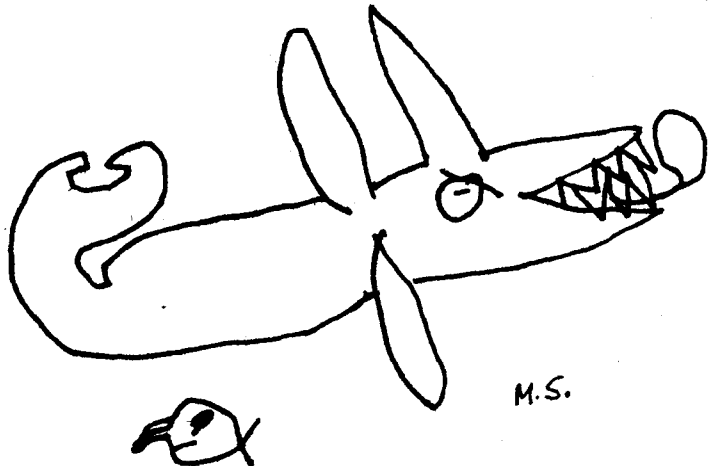
Let me give as examples a few laws in Ontario. The *Education Act* makes truancy a provincial offence. (Offences against provincial laws are also called "quasi-criminal" offences—like criminal offences but not included in the *Criminal Code*.)

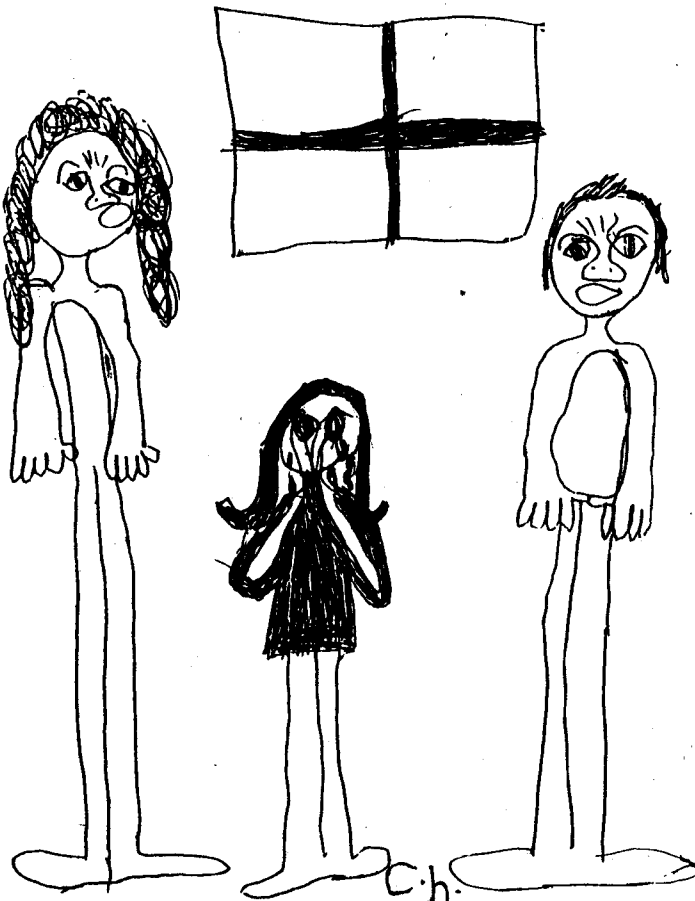
Under the law a child who has committed a quasi-criminal offence can be labelled a "juvenile delinquent", and in many parts of Ontario this is what happens to a child who is truant. In more progressive areas the matter is handled simply as a quasi-criminal offence instead of under the *Juvenile Delinquents Act*, so that the labelling is avoided. But in either case the court has the power to place the child *anywhere* for an indefinite period of time simply because the child has been found to be truant. Adults can be committed indefinitely only if they

are found to be either insane or habitual pathological offenders, but with children different rules apply.

It cannot go unnoticed that many children who do not attend school are bored. Others do not attend because they become so frustrated as a result of lack of appropriate education suited to their needs. Some of the children who do not attend school are learning disabled, fat, or partially blind, or for whatever reason are left behind or ridiculed in the highly social atmosphere of the classroom. These children are not "habitual offenders" or "pathological". They may simply be afraid of their peers, their teachers, and the pressure of the school society.

The existing law focuses, however, solely on the child, as if he were a criminal, someone who has broken the law and deserves a sentence, which may very well be committal to a foster home, or (incredibly) in the not too distant past to a training school—a maximum security facility. You see: going to training school provides the frightened child with a taste of what fear is really about, and that shapes up the child to meet the demands of the future. ➔





Our *Child Welfare Act* was recently amended to ensure that, where state intervention into the family has been found to be needed, taking the child out of the home is a last resort. The lawmakers tried to achieve this by defining "best interests of the child" through a list of relevant criteria, including:

The merits of any plan proposed by the agency that would be caring for the child compared with the merits of the child returning to or remaining with his or her parents ...

Any risk to the child of returning the child to or allowing the child to remain in the care of his or her parent ...

Unfortunately, the section that defines "best interests of the child" does not set out a complete list for determining the meaning of the phrase, but states that "best interests of the child" means

...the best interests of the child in the circumstances having regard, in addition, to all other relevant considerations ... (emphasis added)

As a result, committal to a foster or group home or a mental health facility is still very much based on the values of a particular community and of the judge, and the degree of "coziness" between the judge and the Children's Aid Society as the representative of the state.

Many children are faced with possible committal outside their homes under Ontario's *Child Welfare Act*, not because the family is "unhealthy", but because, for example, a working mother just can not take care of three young children. She would like to. The kids would like her to. But the reality of economics, alas, has so demeaned and enslaved the single parent that committal of a child becomes necessary. The fact is little consolation to the child, who knows and accepts his home as being with his mother, and no amount of "best interests" talk can disguise from the child the fact that he, or his mother, or his brother or sister, is being punished. Why else would they be separated?

In the name of "best interests", and allegedly "mental health", native children are adopted at such a high rate for their population that pretty soon there won't be such a thing as a native family. These kids have traditionally been placed in "white and proper" homes. Years later, as they approach adolescence, many of them become "somewhat upset", wondering how it was in their best interests to be separated from their parents and their culture. Some of these children commit violent acts against property and person in their pursuit of their origins and identity. We then plead insanity on behalf of our clients. We should have pleaded the same years ago when "best interests" prevailed.

A further example. When the *Child Welfare Act* was amended, it was thought to provide the child with the right to legal representation in a child welfare proceeding. Legal representation means the right to choose your own lawyer, and the right to have a confidential relationship with that lawyer, so that in a time of crisis there is a person whom you can trust. This is a right which, as a result of the Ontario Legal Aid Plan, is available to everyone whether or not they can afford to pay a lawyer themselves. It is a right that is basic to the idea of legal assistance, and dis-

tinguishes the legal professional from the non-legal professional.

Nevertheless, that right has effectively disappeared for children. The Office of the Official Guardian (the "new Children's Aid Society"), together with the Ontario Legal Aid Plan--all in the "best interests of the child"--has monopolized the role of representing children, and thereby denied children the right to a lawyer of their own choice. This is true even when the child--hard as it may be to believe--has some knowledge or access to information about lawyers other than the Official Guardian.

*Caveat emptor*: buyer beware! Once a lawyer is appointed for the child through the Office of the Official Guardian, the child must face the fact that that office places the "best interests of the child" first, as a consideration which outweighs all others *including* the wishes and instructions of the child as a client. This reduces the role of the lawyer to that of a government social worker, and gives the Office of the Official Guardian all the trappings of a Children's Aid Society.

Furthermore, the Office of the Official Guardian does not believe that the lawyer's relationship with the child, as a client, is a confidential one, in which the lawyer is bound to respect the privacy of lawyer-client conversations.

As a result of all this, the child is turned from a client into an individual to be incompetent, and who, through the pity of the Court, has the privilege of appointed counsel. That is not what the *Child Welfare Act* says.

On a more positive note, there may be in our life a new federal act dealing with juvenile offenders. A new bill entitled *The Young Offenders Act* (Bill C-61), which promises to replace our 75-year-old *Juvenile Delinquents Act*, received first reading on February 16, 1981. If passed, it will get rid of "best interests" and indefinite commitment within the juvenile justice system.

The act sets out in clear language the rights of an accused child with respect to making statements, undergoing pre-trial confinement, or appearing before the Court. The new act will give the child an

absolute right to be legally represented, one can hope this right will not similarly be compromised by lawyers pretending to be something other than lawyers.

The proposed bill lessens "therapeutic discretion" within the Court by setting up a process of diversion. That is, in certain offences, the accused child will have the opportunity to participate in a program which will allow him or her the opportunity to "pay for" the consequences of the action without having to go through the formal courtroom process. If the child, for whatever reason, chooses not to participate in the program, or, having chosen to participate, fails to do so, then the matter will go back before the Court and the rules of criminal law will be strictly applied. The act seems to clearly describe the players and clearly lay out their rights and duties.

Rights ... duties ... clear language ... clearly defined roles ... all of these help instill a sense of respect in and for the child, and provide the child with the opportunity to understand how things work and the consequences of his or her actions.





# Incest- the secret problem

Discussion has been going on for several years to change the child sexual abuse section of the Criminal Code. Proposed changes to this section had first reading some time ago and were supposed to have been brought back before the House for discussion in April but got put aside because of energy and constitutional talks.

They'll be coming up again for more discussion and approval in the near future, but in the meantime a committee that will look into sexual offences against children and the exploration of children has been given funding for 2½ years by the federal government.

*I was about nine years old when my father first began to come to my bedroom, which I shared with my two sisters, at night and started to touch my breasts and private parts. This would usually happen in the evening when my mother went to the movies or when she was in the living room and my older sister, Anne, was looking at the T.V. or taking a shower. It was within the same year that my father began to have intercourse with me which is putting his penis into my private parts. This was very painful to me when it started. My father told me this was normal and all girls did it with their fathers. When I said I was going to tell my mother or someone about it he said that what my mother does not know would not hurt her. Sometimes he would hit me when I would refuse him and at times he would take me in the car and, as we rode, touch my vagina.*

*(Vincent De Francis,  
Protecting the Child  
Victim of sex Crimes)*

Dr. Robin Badgley and his committee members from across the country have impressive credentials, but so far are playing their cards close to their chest

on the whatfor and whereabouts of their inquiry--probably due to the bad publicity over the shelving of another 2½ year report on child abuse this spring. The contents of that yet unpublished study that looked at how 54 children died in 1977, has been returned to its author by the federal government.

Although the funding of the Justice Committee on Sexual Offences Against Children and Youth (offices located in Toronto) is commendable, the catch is that they'll be reporting back to the federal government *after* the proposed changes in the Criminal Code have been passed by Parliament.

The proposed changes have already met with scepticism by many front line workers. Sandi Sahli, 1980/81 fundraiser for the Ontario Coalition of Rape Crisis Centres, commented on the changes this spring at a Peterborough conference on incest, telling the audience, "They're talking about taking the blood relationships out. A family member will be considered any adult who has the authority or responsibility over that child. They're also going to specify age groups



Patrick Dennis Dowers/Northwest Passage

as well in terms of the amount of damage done. They consider the damage under 14 more severe for the child than 14 to 15 which a lot of people have taken issue with already."

"They've also made the stipulation that the wife be charged as an equal partner if she knew about it and didn't report. If the offender is less than three years older than the victim, he could not be charged. They're very confusing laws to read and I think in fact are going to be worse than the ones we have."

Many provincial agencies prefer to work within their own child welfare acts or the Juvenile Detention Act other than the Criminal Code as it stands. In cases heard on sexual molestation of any kind, consent of the child is usually irrelevant, cases are heard more rapidly and the emphasis is on protecting the child rather than proving whether or not they are "guilty" of the offence. And there is not the same sexism as is found in the Criminal Code.

*.....the sexual molestation and abuse of female children is not regarded seriously by society, is winked at, rationalized and allowed to continue through a complex of customs and mores which applauds the male's sexual aggression and denies the female's pain, humiliation and outrage.*

(Florence Rush,  
R.T. Vol. 2, No.4)

Incest victims, however, can sometimes be their own worst enemies regardless of the legal avenues used to deal with the problem. They often run away from home, mutilate themselves or pursue other "anti-social" behavior to act out their anger and because of this are often not believed when they finally tell the authorities. The guilt incest victims feel over the event is further aggravated if the family is broken up when the act is found out and/or the child is sent away from the home rather than the offender.

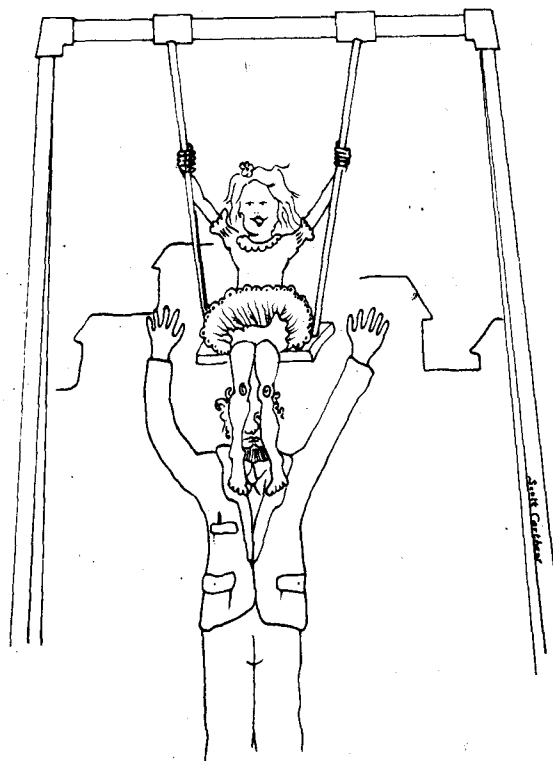
Ottie Lockey of the Women's Counseling Referral and Education Centre in Toronto, charges that many Children's Aid Societies don't know what to do with incest victims despite laws in some of the provinces that encourage adults to report child abuse to the authorities. In an

article in the May issue of Broadside, a national feminist publication, she said,

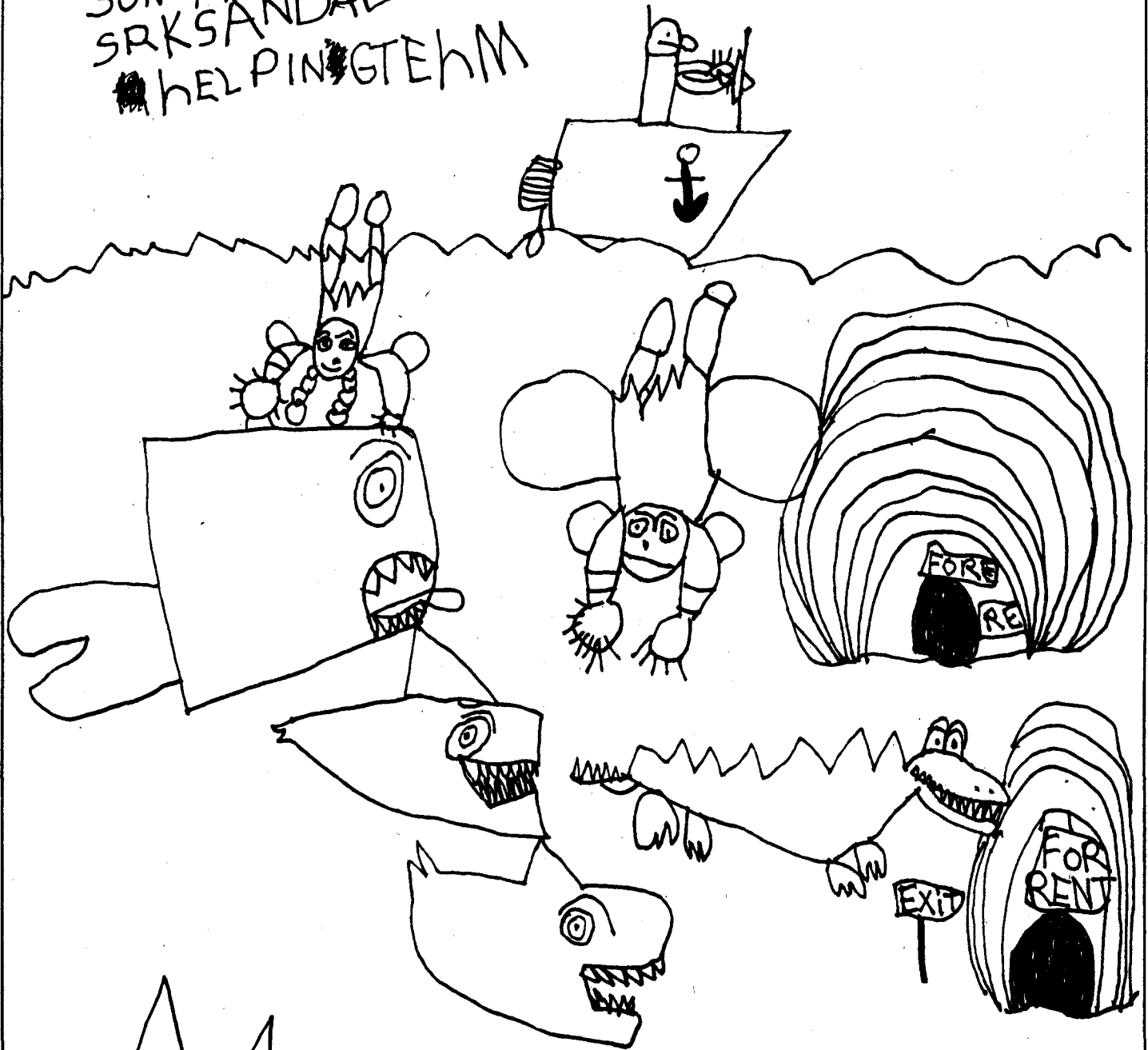
*"If Toronto is any example, CAS workers have no ideas what to do. They are overworked, hampered by bureaucracy and with no special training in dealing with incest. If the father/male adult is 'respectable' and denies the charges, the tendency is to blame the child."*

About 90% of adult/child incest takes place between father and daughter with diminishing percentages between father and son, mother and daughter and mother and son.

The physical damage a child may suffer from being raped or molested by a family member may be only temporary, but the psychological damage done often lasts forever. Over 5% of psychiatric patients have been incest victims.



SOMMENAREGO GOING TO TRY TO GET  
SOM ANMALS LEC  
SRKSANDAL AGATR SINTOACAVANDA WALEL  
HELPINGTEHM



MICHAEL

# SPRED

## The Society for the Protection of the Rights of the Emotionally Distraught



*Shirley Hauzer and Fred Serafino*

The next time someone tells you to "spread your wings and take a flying leap" don't think of the birds, think of the Society for the Protection of the Rights of the Emotionally Distraught, better known as SPRED.

SPRED, a self-help group of ex-psychiatric "patients" has been operating in the Niagara region of Ontario for two years now. The history behind this group is an unusual one. It all goes back to March 1979 when Bill Jeffries, a member of Friends of Schizophrenics (a self-help group for the relatives and friends of schizophrenics) came to the Niagara Falls public library to encourage people there to start another chapter.

Fred Serafino and Shirley Hauzer, original SPRED founders, remember that 35 people showed up. But when it came time to actually organizing the chapter, the "ex-patients", who had come out in full force to the meeting, ended up doing most of the work. In no time a self-help group of ex-"patients" had formed, many of them drawn from a group of friends Fred had made at the Hamilton Psychiatric Hospital from 1974-1976.

It was only after the Niagara Falls group became a chapter of Friends of Schizophrenics, that a problem arose over the fact that it wasn't, in fact, attracting "friends" of schizophrenics.

Says Serafino, "We didn't think about that. We were just interested in doing something--period. There are so many things being done for the careers of social workers, but no one is interested in making social reforms".

The chapter's name was later changed to encourage people to join their organization.

Because they weren't the same as other Friends of Schizophrenic chapters, SPRED was required to pull together an executive board of parents and friends of some of the members, (some of whom had been involved with the group all along) and find prominent people in the community to serve on the advisory board - a prerequisite for membership with Friends of Schizophrenics--but SPRED members still run virtually the whole show. Their continued ties with Friends of Schizophrenics has enabled them to receive some money to help finance the newsletter they send out free to interested people.

SPRED now boasts a core of 35 to 40 members who have paid the \$5.00 Friends of Schizophrenics fee and at least a hundred other people who drop in to take part in various activities and functions by the group. An article written about

## *The ex-patients ended up doing most of the work.*

them in the St.Catharines' Standard has helped to create a satellite group in that city as well. To its rural members, SPRED urges moving to the city where there are better systems and more contact with other members.

It's taken some effort, however, to dispell the bad feeling of staff at the Greater Niagara General Hospital over the formation of the group. Although Dr. Wallace Mitchell, head of the psychiatry department at the hospital, has been a strong supporter of self-help, other members accused SPRED of encouraging "patients" to go off drugs "cold turkey" in the beginning. "We encourage people to speak up with their doctors; several people have come off medication because of SPRED", admits Shirley, "but we don't believe in cold turkey".

Although SPRED has had its moments of disagreement with Friends of Schizophrenics, the relationship between the two groups appears to have been mutually

beneficial. SPRED believes it has been largely responsible for the shift in direction at the latest Friends of Schizophrenics conference from the scientific and theoretical of last year to a practical, self-help approach this year.

At the latest conference, the Friends of Schizophrenics executive met with SPRED members to receive input to expand their constitution to allow for more "ex-patient" self-help "programs" within the organization, adopted later during the same conference.

## Unemployment continues to be the biggest problem

For its part, SPRED members have recently acquired permanent headquarters thanks to a generous board member who bought a house for the group in the downtown core of Niagara Falls. Part of the house will be used as a private residence for five members with the lower floor and basement to be used for support group meetings and

a coffee house.

Unemployment continues to be one of the biggest problems with few jobs to be found in the region. SPRED is presently attempting to arrange a split job scheme where members split full-time jobs into two parts so that more people will be employed, and trying to sell the idea to community groups and the labour board who might provide the jobs.

In the offing: one board member has offered to put up money to start a natural food restaurant and possibly a co-op foodstore.

Meanwhile SPRED continues to spread the work through speaking engagements and through its involvement in a Community Mental Health Action Coalition and a district Health Council Mental Health Task Force it has been asked to sit on.

SPRED, 4927 Morrison, Niagara Falls, Ont.  
L2E 2C4. 358-7659



## New self-help groups

A number of new self-help groups have recently been formed in Ontario and in Saskatchewan.

A group calling itself SETI--Self Esteem Through Independence--has been started in London, Ontario, largely through the efforts of a Canadian Mental Health Association worker who has also been a psychiatric inmate, and several former and present inmates in London itself.

ON OUR OWN was invited by *Mental Health/London* to speak about self-help during Mental Health week last spring, then invited back again by several ex-inmates who had attended the first event to lend their support to the London people who wanted to start up their own group.

SETI is now in the process of becoming incorporated and is looking around for office space and space for a regular drop-in. Since *Mental Health/London* has been encouraging former and present inmates to start a group, London Psychiatric Hospital has withdrawn from the CMHA board in that city, citing a "conflict of interest"

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In Saskatchewan, as our last *Phoenix Rising* indicated, a lot of exciting developments are occurring through the in-

quiry the CMHA there has initiated into the mental health system.

In the spring Marilyn Sarti of the Mental Patients Association in Vancouver was invited to Saskatchewan to talk about her self-help organization, and spent a week of constant activity talking to various groups throughout the province.

In Saskatoon she talked to a self-help group of inmates called New Start which has been going since last fall. New Start hopes to open a half-way house in the distant future, and is trying to get a drop-in going. In the meantime they are operating out of CMHA offices and working towards setting up an odd job service, holding various workshops, teaching crafts and counselling their own members.

In Regina, another self-help group called By Ourselves has formed; it opened a drop-in on Broad Street in May. Some of the members live in a group home called Phoenix House--(how coincidental can you get?).

For the addresses of these groups check our listings in the back and front of this issue of *Phoenix Rising*.



# People

## David Pettersen

Ten years ago a social worker at the North Bay Psychiatric Hospital told David Pettersen he would "never be able to work again." The social worker and other members of staff were convinced that Pettersen was "lazy" even though he had had 120 shock treatments in a 2½-year period and was on massive doses of stelazine.

"Getting shock was one of the most frightening things I had ever experienced" recounts Pettersen. "It was like being in hell. I had it the old way. I was injected with a drug that paralysed me so I couldn't move or even breathe, and then I was wheeled into the room and waited to be put asleep with the shock. It was like being in a concentration camp".

***"It was like being in a concentration camp."***

Today Pettersen is a steady worker with Go Temp, an Ontario government agency that provides workers to government offices on a temporary basis, and has missed only a day and a half through sickness in the last two years. He hasn't been back in a psychiatric hospital since 1970.

Pettersen's been working with Go Temp since 1976, and has been at his latest assignment as a data control clerk for the last two years. "I was only supposed to be there for six months," explains Pettersen, "but they liked my work." He describes his present boss as very supportive and his working conditions good.

## Shock Docs .....

If you, a member of your family, or a friend has received shock from a Canadian doctor and wants his or her name added to our list, send us the name, hospital affiliation and city. PLEASE SIGN YOUR LETTER; we will not use names submitted anonymously. However, we will at your request withhold your name. Additions to the list should be sent to: Shock Doctor List, Phoenix Rising, Box 7251, Station A, Toronto, Ontario M5W 1X9.

Pettersen first went into a psychiatric hospital when he was 17. Diagnosed as "manic depressive", Pettersen was in and out of psychiatric hospitals for twenty years.



Most of his endeavours during the sixties didn't work out, and at one point he was badly burned in a hotel fire in St. John, New Brunswick, when he had to run through a hallway of flames to escape. Pettersen still bears faint scars from this incident on his arms. The depression that resulted from the fire landed him back in North Bay Psychiatric Hospital in 1967.

After his discharge Pettersen moved back in with his parents and started working again. "I wasn't offered the opportunity not to work," says Pettersen, who was not receiving benefits at the time.

Pettersen continued to take high doses of Stelazine--30 milligrams a day into the early seventies. This and the stress of trying to work with a mind clouded with drugs and the after-effects of shock made him so anxious he felt like a "fighter pilot". "I wouldn't have experienced a lot of the pain of the seventies if I had been on disability pension," says Pettersen, but adds that the initial "pain" was worth the "gain".

With the assistance of a sympathetic "client-centred" psychiatrist, Pettersen

was able to reduce his dosage of Stelazine to the four milligrams that he continues to take today. Although Pettersen had a drug holiday in the mid-seventies, he finds the low dosage helps him handle his mood swings and keep a job.

Pettersen credits religion, a close friend he met in the mid-seventies, and his psychiatrist for helping him stay out of hospital for the last twelve years.

When Pettersen was depressed and between assignments in the seventies, and wanted to go back to the hospital, his psychiatrist talked him out of it and urged him to go back to school and upgrade his job skills instead.

His friend has given him the motivation to force himself to go in for work even if he's had difficulty sleeping the night before, which sometimes happens to him. "It takes more courage to stay up all night and go into work, than to be a person who sleeps soundly and then goes into work." Christianity has given him the ability to forgive and forget the past. "It gives you good things to think about. It gives you a sense of purpose when things aren't rosy or even when they are rosy".

Since Pettersen started doing volunteer work Saturday mornings at the Scott Mission, washing dishes for 600 men, he feels a lot clearer and more energetic on the week-ends. "One thing that experience at the Mission has done for me is that it's helped me fight lethargy. I'm not as sensitive as I was before."

## *"I'm not as sensitive as I was before."*

And since he's reduced his dosage of Stelazine, he's been able to do a lot more and see more people.

Advice for other ex-psychiatric inmates who might be trying to get back on their feet again:

"Some people are cruel. A person who's out of hospital and runs into a person like that will want to quit. If you have enough other positive things going on in your life you'll be able to shrug it off."

*"People" is a regular feature of Phoenix Rising. If you have any suggestions of people you think should be included, please let us know.*

# Canadian Crisis Numbers

## CALGARY

Suicide Crisis Line	252-3111
Advice, Info & Direction Centre (24 hrs. every day)	268-2341
Distress Centre-Drug Centre	266-1605

## FREDERICTON

Chimo Help & Assistance(for people in crisis)	455-9464
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Oromocto Information Service Centre	357-9809
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## HALIFAX

Help Line	422-7444
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## MONTREAL

Distress Centre	935-1101
Referral Centre of Greater Montreal request for information	931-2292

## REGINA

Community Switchboard	352-6443
Crisis Line	525-5333

## ST. JOHN'S

Citizen's Rights Association	753-7062
Community Services Council	753-7062

## TORONTO

Distress Centre 1 (24 hours)	598-1121
Distress Centre 2 (24 hours)	486-1456
Suicide Prevention Bureau	368-3111
Information and Referral Centre	863-0505

## VANCOUVER

Crisis Centre	733-4111
Greater Vancouver Info & Referral Service	736-3661

## WINNIPEG

Suicide Prevention	
Salvation Army	943-4306
Klinic	786-8686
Contact Community Information and Referral	944-8555

## YELLOWKNIFE

Help Distress Centre	873-3555
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# phoenix pharmacy

## Ritalin

Ritalin is the brand name of an amphetamine-like stimulant commonly prescribed for Minimal Brain Dysfunction (MBD) in children, or as it is now been re-called, "Attention Deficit Disorder". Ritalin, genetically known as methylphenidate hydrochloride, is manufactured by CIBA. It is also sold by different companies under the brand names of Methidate, and less commonly, Apo.

At least 300 symptoms identified by a University of Arkansas Medical Centre task force in 1966 have been used to justify prescribing stimulant drugs for MBD children including:

"Spotty or patchy intellectual deficits," "achievement low in some areas, high in others," "hyperkinesis" or its opposite "hypokinesis," "general awkwardness," "slowness in finishing work," "reading disabilities," "arithmetic disabilities," "poor printing, writing, or drawing ability," "easy fatigability," "peer group relationships generally poor," "thumb-sucking, nail-biting, head-hanging and teeth-grinding in the young child," "slow to toilet train," "explosive," "sleep abnormally light or deep," "physically immature, or physical development normal or advanced for age," "possibly antisocial behaviour," "possibly negative and aggressive toward authority," "sweet and eventempered, cooperative and friendly," "impaired ability to make decisions, particularly from many choices."

But the fact is, after more than 20 years of using Ritalin and other amphetamine-like drugs for MBD in children, no one has proven that this syndrome is actually a "disease" or that drug use effectively changes behaviour in the long run.

Studies of the long-term effects of using Ritalin have found that the drug is most successful at *controlling* or *managing* behavior but does not improve a child's scholastic skills any more than

they would normally develop should that child not be on drugs. Forty percent of



Morty Goldmacher

"hyperactive" children do not even respond to stimulants commonly prescribed to increase attention and concentration.

Most studies indicate that while taking the drug, many continue to have serious social and behavioral problems long after discontinuing medication. One study done at the University of Illinois Champagne-Orbana in the late seventies by Professor Robert Sprague, found that, "what may be the basic core problem in hyperactivity remains after treatment is stopped. And that is a lifelong difficulty with inattention and social skills." Sprague's results have been duplicated in other studies done in North America.

Ritalin is the preferred drug prescribed for children over other stimulants such as Dexadrine, Benzadrine and the new drug Cylert (whose questionable pre-release tests are documented in the book *The Myth of the Hyperactive Child*,) because it has less unpleasant effects than any of the other drugs.

Most experts do agree that these



stimulants make children more manageable but how and why the drugs work the way they do is still not fully understood. The belief that Ritalin and other amphetamine-like drugs act in a paradoxical manner by sedating over-active children has been disproven: they act in a similar manner on "normal" children and may also stimulate both "hyperactive" and "normal" children. Stimulants have been used on "hyperactive" adults to calm them down and on the aged to "speed" them up.

Even the syndrome of "hyperactivity" has been challenged. That it appears to be a phenomena more common to North America than Europe, casts serious doubt on the actual true incidence of this condition. (On the Isle of Wight, just off the coast of England, only one twelve-year-old for every thousand is reported to be hyperactive. In the United States one child in 500 to 600 children is considered hyperactive, and questionnaires done on the problem have found American parents and teachers consider 50% of young people to be hyperactive.)

Many researchers and specialists believe "overactivity" or "hyperactivity" is caused by a variety of influences ranging from social/economic/family problems, to personality clashes with school teachers and overly large classroom sizes to environmental causes. Because boys are labelled "hyperactive" in an almost 9 out of 10 ratio to girls, the term "hyperactivity" has also been implicated as an intolerance for natural boyhood behavior.

Early results from rigorously con-

trolled tests indicate that some hyperactive children may show behavioral improvement when on the Feingold diet which eliminates additives, dyes and foods with salicylates (like apples and tomatoes) but less dramatic short-term behavior changes than those who take stimulants.

Behavior modification techniques used with and without drugs have been found to be effective with some children. Researchers are also looking into the effect of fluorescent lighting and the possible over-absorption of lead and other trace metals by these children.

## Taking It

Nobody said bringing up children was going to be easy and bringing up an over-active child can be more than a handful. If every conceivable reason for "hyperactivity" has been investigated and everything possible has been done to rectify the situation and the use of Ritalin is still indicated, be aware of the following side effects:

(These side effects also apply to adults and the aged who may be taking this drug).

Growth retardation (in weight and/or height) has been reported in children who have taken this drug. Growth should be carefully monitored during long-term use. Ritalin is not recommended for use in children under six years of age. If improvement is not observed after appropriate dosage adjustments over a one-month period, the drug should be discontinued. Ritalin should not be taken later than 3:00 p.m. A daily dosage above 60 milligrams is not recommended.

EXPECTED SIDE EFFECTS: insomnia, nervousness.

ADVERSE EFFECTS: (If these develop, stop taking this drug and see your doctor as soon as possible).

Mild: Skin rash, hives, drug fever, joint pains, reduced appetite, weight loss, nausea, abdominal discomfort, vomiting, headache, dizziness, drowsiness, rapid or forceful heart palpitation.

Serious: Severe skin reactions, extensive bruising.

This drug has been known to cause 'paranoia' and other 'psychotic' behavior in some people.

Consult your doctor and use with caution if you have epilepsy, high blood pressure, or are taking any MAO inhibitor drugs. This drug should *not* be taken if you have glaucoma. Ritalin may enhance

the effect of the following drugs: oral anticoagulants, anti-convulsants, phenylbutazone, tricyclic antidepressants, atropine-like drugs. Ritalin may decrease the effect of guanethidine. A blood cell count should be done regularly while on this drug.

The following foods (rich in tyramine) and drinks should be avoided while on Ritalin:

Aged cheese of all kinds

Avocado

Banana Skins

Beef & chicken livers (unless fresh and used at once)

"Bovril" extract

Broad Bean pods

Chocolate

Figs, canned

Fish, canned

Herring, pickled

"Marmite" extract

Meat extracts

Meat tenderizers

Sour cream

Raisins

Raspberries

Soy Sauce

Yeast extracts

Beer (un-

pasteurized)

Chianti wine

Sherry wine

Vermouth

Do not take any non-prescription items for cough, colds or sinus problems while on Ritalin without first checking with your doctor.

Smaller doses of this drug are advisable for older people. This drug should not be taken during pregnancy or while nursing. Tolerance to this drug develops quickly; Ritalin should be discontinued slowly under a doctor's supervision.

\*\*\* Ritalin should not be taken in amounts exceeding your prescription. This drug can be dangerous if taken in an over-dose.

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### **What's new in tranquilizers?**

Lectopam (generic name - bromozepam) is a new minor tranquilizer which has been introduced into Canada by its creators, Hoffman La Roche Ltd. This drug is chemically related to Valium (trade name), and has a similar action. However a smartly designed information booklet prepared by La Roche for distribution to doctors, along with samples of Lectopam, shows selected studies which prove Lectopam to be far superior to any other tranquilizer in its class.

The booklet does not include other studies which indicate Lectopam to be no better or worse than most of the older tranquilizers. This booklet also fails to emphasize that Lectopam does have similar side effects as most sedatives, including: blurred vision, headaches, mental confusion and muscle weakness, just to name a few.

Lectopam has an addiction potential, along with severe withdrawal symptoms such as convulsions, vomiting, insomnia and memory loss which will occur on abrupt stoppage of the medication. La Roche doesn't deny that there are some adverse effects of the drug, but they claim that the side effects and addiction potential are less frequent and severe with Lectopam than with other similar drugs. This claim however has not been proven conclusively by scientific studies.

Unfortunately Lectopam is only marketed by the Hoffmann La Roche Company, with the less expensive generic Bromazepam being non-existent. This causes Lectopam to be over double the price of no-name Valium (viz. Diazepam) with questionable, if any, benefits over Diazepam.





# what's happening

## Man. CIA victim settles for \$\$

Val Orlikow, wife of Winnipeg M.P. David Orlikow, has settled out of court for \$50,000 plus the costs of testimony by experts in a lawsuit against a Montreal Hospital. She and 52 others had been subjected to brainwashing experiments funded by the U.S. Central Intelligence Agency under the guise of the now-defunct Society for the Investigation of Human Ecology. Her other lawsuit against the C.I.A. is still pending.

Orlikow's nightmare began 25 years ago when she sought psychiatric help for acute depression. She visited the Allan Memorial Institute run by the Royal Victoria Hospital and came under the personal care of its director, the late Dr. D. Ewen Cameron.

From 1956 to 1964, she was treated with amphetamines, barbituates and massive doses of LSD. According to hospital documents released in court, as many as nine drugs were given to her at one time.

After LSD injections which made her feel *"like a squirrel climbing the walls of a cage"*, Mrs. Orlikow had to listen to repeated tape messages at least five hours a day and write continuously whatever thoughts came into her head. Known as *"psychic driving"*, these sessions attempted to *"wash the brain clean and break down the patient"* in order to manipulate behaviour.

One psychiatrist who testified at the trial described her ordeal as *"psychological torture"*, and noted that Dr. Cameron's methods were similar to techniques used by U.S. intelligence in the interrogation of suspected double agents. Mrs. Orlikow never knew that Dr. Cameron was conducting brainwashing experiments for the CIA as part of a \$25 million mind-control program. Documents revealing the information were released much later.

Hospital lawyer Alex Paterson feels that the hospital *"was taken for a ride"* as much as she was and hopes the \$50,000 (the third offer) will help Mrs. Orlikow pursue her other lawsuit against the CIA. She is seeking damages of \$1 million from the CIA for financing Dr. Cameron's experiments along with four other Canadians; Jean-Charles Page, Robert Logie, Jeanine Huard and Lillian Stadler, also treated at the AMI, who are seeking \$1 million each as well.

But it isn't a matter of money. With travel and expenses alone the Orlikows estimate "justice" has cost them at least \$150,000. Rather, it is their hope that litigation will deter hospitals in the future from undertaking experimental therapy without first advising the patient, and then obtaining permission.

## New Ontario Human Rights legislation

New Ontario human rights legislation, slated to be passed this fall, will make it illegal to discriminate against the physically handicapped, "mentally ill" or the mentally disabled, but already Bill 7 has been the subject of heated debate, generating responses that range from acclaim to condemnation.

The biggest complaint about the bill has been over the sweeping powers given to Human Rights Commission investigators. Their increased power will make it possible for them to search and seize information relevant to a case of discrimination in any place that is not a dwelling, and to question employers and employees. Yet without this power it is almost impossible to prove (or disprove) that a grievor has been

denied employment or lodgings for prohibited reasons since the evidence needed is usually in the employers' and landlords' records.

Critics of the bill have also expressed concern over the clause that will make it illegal not to hire someone on the basis of his or her handicap. It has been interpreted to mean that the employer *has* to hire the handicapped individual even if he or she doesn't have the skills for the job. In actuality the bill makes it clear that the employer cannot refuse a job to an otherwise qualified applicant just because the person is physically or mentally handicapped.

Other concerns have been expressed over accommodation rights: will a landlord have the right to deny lodgings to a former axe-murderer? If the person in question is dangerous to himself or herself, or to others, then he or she would not have been released. After all, how many of the 50,000 or more Ontario residents who have had some form of psychiatric treatment are dangerous?

John Southern, Vice-President and Lobbyist for BOOST (Blind Organization of Ontario with Self-help Tactics) feels legislation hasn't gone far enough. He explains:

"Reasonable accommodation has not been dealt with adequately; there should be an allowance for job modifications, re-aligning some duties which would result in new job descriptions."

For example, take a blind switchboard operator who is capable of doing 9/10ths of her job—everything except photocopying. That duty could be assigned to someone else and in turn she would assume another task. Southern also feels that the bill should take responsibility for modification needed by the handicapped to assure physical access to the job, as well as adjustments on the job site itself.

The area of homosexuality has not been dealt with either, although there is a clause that will make it illegal for an employer to harass an employee.

The bottom line of Bill 7 is that it attempts to end discrimination against the physically or mentally handicapped in employment and elsewhere. Labour Minister Robert Elgie, who introduced the legislation, feels "lack of understanding is the chief problem. The handicapped usually have a lower rate of absenteeism, and a better health and safety record."

## P.E.I. bill too sweeping

Two bills passed by the legislature without opposition give police in Prince Edward Island the authority to abduct people from their home without a warrant and detain them without laying charges until a doctor decides whether they should be forced to have "treatment". Both bills assigning police sweeping powers to deal with alcoholics or drug addicts await official proclamation from the lieutenant-governor.

A research co-ordinator for the Citizens Commission on Human Rights says the PEI legislation "is worse than" the Heroin Treatment Act in British Columbia that requires heroin addicts to receive treatment (which is now under appeal). The PEI law "allows a policeman to enter a private household and pick somebody up without a warrant because the officer *thinks* he is an alcoholic".

Amendments to both the PEI Mental Health Act and the Addiction Service Act place the onus on the officer. He decides whether an individual will be removed from private premises. The criteria for "judgement" is suspicion that the said citizen is

"suffering from a mental disorder caused by the use of alcohol or other chemical substances".



The second bill gives the police the power to take into custody any

*Mt. Adams Gazette/cpf*

person found in a public place "apparently in an intoxicated condition". In both cases, the individual may be taken to the "appropriate" treatment facility.

There, he or she must be mentally examined within 72 hours. If the doctor decides the person needs further treatment or should be held for his own safety or that of others, the individual can be detained for 14 days; if the centre's director decides that the person is a chronic alcoholic requiring long-term care, he can apply for a committal order up

to 6 months for the individual. In addition, should anyone who has undergone treatment wish to file for damages against the director, doctors and staff, the new act will not recognize the civil suit.

## *Alberta social services rapped - again*

Allegations of physical abuse of mentally handicapped trainees in an Alberta vocational workshop has renewed public criticism of the state of social services and the treatment of the province's most vulnerable clients in this energy rich jurisdiction.

A former staff member at the Horizons Unlimited workshop in Wetaskiwin, Alberta and a former office manager at the local Wetaskiwin District Association for the Mentally Retarded allege that one Horizon employee repeatedly abused trainees.

A 57-year-old trainee was hit on the back with a stick for disobeying an order. A young mentally handicapped girl was slapped for throwing a purse at another staff employee. Also a 23-year-old man, complaining of sickness, was supposedly obliged to spend one day lying down in a cloakroom. It was two days before the man was admitted to a hospital, where he was found to be suffering from an inflamed pancreas.

The Horizons board has denied the allegations, insisting the charges "have been blown completely out of proportion". Horizons officials deny any physical abuse, but they admit the staff member in question was reprimanded for verbally abusing trainees. They say the behaviour of the individual has improved since the incident.

There have been complaints that staff in the vocational workshops for the mentally handicapped are inadequately trained—they are not required in Alberta to have post secondary educational training according to a story in the Globe and Mail.

## *Catch this book!*

*Mentally Handicapped Love* is proving to be a best seller. Written by Marie Putman, a 20-year-old mentally handicapped woman from Surrey, B.C., this personal journal detailing her daily experiences,

has sold in the thousands and is being considered by the United Nations for distribution to mark the International Year of the Disabled.

Published by Harbour Publishing in Vancouver, with all its spelling, grammatical errors, and unfinished sentences intact, Putman's honest and charming style is what makes the book work.

Her publisher says it was submitted in looseleaf and written in ballpoint and purple and red crayon.

Putman and her girlfriend, a victim of Down's Syndrome, are living in a Vancouver group home, but are planning to find an apartment of their own in the near future.

She says she wrote the book and had it published with the idea in mind that it would enable her to become more independent.

## *Farmer story soon to be film*

Keep your eyes open for a soon-to-be-released film on the tragic story of Francis Farmer, directed by Mel Brooks. Farmer, a famous American actress who rose to prominence in the 1930s, spent several years of her life languishing in a mental asylum because she didn't agree with her mother and displeased government officials. (She supported migrant workers.) Let's hope Brooks takes this subject seriously. Indications are that he will. Brooks will be working closely with William Arnold, who wrote *Shadowland* (reviewed in the Women and Psychiatry issue of PHOENIX RISING, Vol. 1, No. 4) on the script.

## *Soviet psychiatrist sentenced*

In a Soviet Union court a Soviet psychiatrist has been sentenced to seven years in prison and five years internal exile after pronouncing a dissident sane even though the dissident had been sent to a psychiatric hospital.

Anatoly Koryagin, according to dissident sources, was ordered jailed for anti-Soviet agitation following a trial in the Ukraine that lasted three days.

The psychiatrist was alleged to have told Western reporters that a dissident mining engineer had been declared mentally incompetent after he complained of conditions in Soviet mines.

# Psychiatric Aftercare in Metro

Toronto's Community Resources Consultants and the Clarke Institute of Psychiatry have recently published an excellent report, titled *Psychiatric Aftercare in Metropolitan Toronto*. The report goes a long way toward pointing out the total inadequacy of aftercare services in Metro.

The report is based on over 700 interviews with mental health professionals and over 500 interviews with discharged patients from four psychiatric facilities in Toronto and just outside the city—a total of 744 discharges. Clearly shown is the high rate of the "revolving door syndrome" that has been occurring in Metro Toronto as the result of deinstitutionalization.

The percentages are staggering. In the follow-up group the percentages of patients who ended up back in psychiatric facilities were:

6 months: 30-40% 1 year: 35-50%  
3-5 years: 65-75%

(In 1941, 25% of patients discharged ended up back in an institution. Of course, in the good old days patients stayed in hospitals longer—sometimes for their whole lives.) Only 10% to 30% of discharged patients ended up with full-time employment.

*Psychiatric Aftercare in Metropolitan Toronto* is not laden with jargon, but a number of terms such as AMA (Against Medical Advice) are not explained, possibly in the belief that laymen will not be reading this report. The tables and charts are interesting and revealing, but possibly a bit misleading. For instance, suicide is not included in the recidivism statistics, or anywhere else for that matter.

The report could have been more critical if it had made more use of its statistics on class, sex, ethnicity and other possible causes of discrimination. It's left to the reader to interpret these data. The report does indicate that psychiatric services are overused by the less "ill", or so-called "neurotic", displacing the more seriously troubled who may need these services more urgently.

Hospitals and other facilities that practise the medical model were found by the study to be receiving disproportion-

ately more money than the services necessary for inmate integration into the community (24:1). Since the report was published, however, this ratio has been slightly altered by a recent injection of money into community services by the Ministry of Health.

The funding derived through savings from deinstitutionalization is being ploughed back into institutions rather than into aftercare. This is shocking, and the government's priorities in this respect should be seriously questioned. According to evidence from other studies and jurisdictions cited in the report, community-based services are definitely more effective than institutions, however modern and well-staffed. People, not professionals, need to be underwritten. Caring services, not sterile buildings, need to be put in place.

The report is receiving wide distribution, and is available from Community Resources Consultants of Toronto, 120 Eglinton Ave. E. (416 -635-0447)

## Woman wins \$4.6 million malpractice suit

A malpractice suit in California against a psychiatrist has resulted in a San Diego woman being awarded \$4.6 million by a Supreme Court jury.

Evelyn Walker, 41, testified she suffered psychological damage after her psychiatrist seduced her during therapy sessions. Ms. Walker's lawyer told the court that his client had lost her first husband, the custody of her two children, and her share of the community property.

After psychiatrist Dr. Zane Parzen broke off his sexual relations with her, her emotional condition went downhill and she attempted suicide 30 times. Dr. Parzen who admitted "medical and ethical malpractice" had his professional license lifted by the state of California.





# commentary

## SPECIAL EDUCATION?

by David Melville and Nancy Masters

The following article was written by two Toronto elementary school teachers actively involved in community affairs. The authors are partners in Emerging Editions, an education enterprise committed to raising people's awareness of current education issues.

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The number of special education programs has increased in the last 20 years, in Ontario and across Canada as rising numbers of troubled children surface in our school system. This increase will continue, since most provinces at this time are studying special education with a view to recommending changes.

In Ontario, the Education Amendments Act., known as Bill 82, will guarantee special education placements for all exceptional children. Ironically, the Ontario Ministry of Education, which has authorized the bill, has not made a financial commitment to new special education programs yet, despite its political commitment to new "exceptional children". Therefore, any local board which is willing to go ahead with new special education program must do it on its own financially.

Bill 82 has a five-year implementation time line, yet some boards have immediately stepped into it despite no clear cut funding, and may be leaving themselves open to economic confusion without the necessary fiscal dollars for the new programs.

The Toronto Board of Education is

one such board. It attempted unsuccessfully in May of this year to re-assign staff already slated for regular classrooms into new special education programs, but postponed its decision due to large parent-community outcry. One immediate effect of this attempt would have been to increase class sizes (i.e. the number of students in a class) significantly.

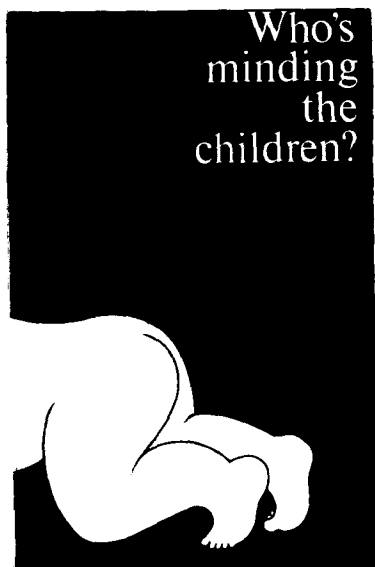
With more special education programs being established in Ontario, more teachers are being lured to become certified to teach these programs. In Toronto, teachers and programs are pitted unwittingly against one another, under the guise of importance or priority. Here, most special education teachers and the programs they teach are protected; they are not affected by education cutbacks and teacher firings.

In theory Bill 82 is to provide more opportunity for parents to be involved in the placement of their children. Just how much it will differ from present practices is not clear.

In Toronto, parents are invited to admissions board hearings which determine the best placement for their children. Hearings, however, are held during the day when most parents are at work either in the home or outside of it, and cannot afford to take off a day without pay, or cannot afford a babysitter.

Even when a parent does attend, the process can be a confusing and intimidating experience. In many cases parents are simply there to listen; to agree to the school's decision. Many parents trust the school to make the decision regarding their child's future education and the board more often than not simply rubber stamps the decision the school officials have already made.

Some children do require remedial help in school and should have the right to receive it. But special education programs can have a negative effect on children, particularly when they are removed from regular classrooms and





placed in special classes with children who have similar disabilities.

The special education notion emphasizes any student's weakness can become a self-fulfilling prophecy in a society where attention seeking plays a major role in overcoming insecurity and fear. By isolating children in special education programs from "regular" students, we begin to destroy the very basis for understanding and respecting different abilities that we should be encouraging in children and adults.

Once separated from regular classrooms, many special education students begin to believe the messages and labels that are often given to them by teachers and peers such as "stupid" or "different" or "difficult". The division between children with different abilities becomes entrenched when elementary special education students are placed in vocational or low academic secondary programs, too often ending up frustrated and unemployed when they find out that community college students are getting the vocational jobs they were promised and trained for. Others simply drop out, bored by the courses and programs they are streamed into taking.

Not surprisingly, all the clearly defined "inner-city" students are at a disadvantage in the school system where the child's behavior is deemed more important than the social or family problems causing it. Working class families have a disproportionately high number of family members who become students in special education programs rather than middle and upper class families, as do immigrant families, single parent families and subsidised families.

The cornerstone of many special education programs has been the adaptation of teaching methods and materials and carefully planned step-by-step lessons, to meet the special needs of students. This type of individual programming does not occur in regular classrooms to anywhere near the extent it does in special education programs.

One alternative we have found successful is "withdrawal", a program presently used in some of the schools in the Toronto school system. This is when students who are having difficulties are withdrawn for short periods of special education while attending regular classes. The benefits are obvious: there's less teacher burn-out and the students get the kind of

## THE SUM OF ME

*by Beverley Seabrook Steven*

I am a whole person  
but I cannot give the whole of me  
to each of you.

Therefore, each of you that has  
a part of me  
helps to make me complete;

with the exception of  
the secret part I keep  
for me.

attention they need without being thought of as the odd person out by the other students.

In order for this system to work, however, classroom sizes must be small enough to enable teachers to plan and work more closely and more often with students. With declining enrolment, this program could be carried out extensively if there was less concern with recruiting more and more teachers to special education and more concern with expanding and renewing the skills of all teachers.

ALL teachers should be required to take courses or be involved in workshops in observation, analysis, evaluation and programming for children with special needs.

Staffing or funding special education classes at the expense of other programs needed in a school community is not the way to help increasingly troubled children in our school system. The allocation of money must be faced and resolved before new special education programs are put into operation. And if we want to decrease the need for special education, we have to face the problems and conditions that may exist in the child's world with the same zeal that we are developing new special education programs.

If we fail to concern ourselves with the child's family, neighbourhood and culture, we fail to meet his or her real needs.

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non-sexist children's books  
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# letters continued

Doctor. Upon questioning him, I discovered that I was not certified and never had been. I arranged to sign myself out the next day.

I had no money so I hitch-hiked back to Toronto. I had two large suitcases and two shopping bags to carry. It was snowing heavily--about a foot of snow had accumulated.

It was a frosty Friday morning!

*Ellen Northcott,  
Toronto, Ont.*



It is almost two years since I was discharged from the psychiatric ward of the Mount Sinai Hospital where I was a patient for eight months. When I was discharged, I was instructed to follow a regular dosage of Perphenazine at a level far exceeding the ambulatory limits. For the next 10 months I slept an average of 14 hours a day. I was unable to walk in sun-

## THE STREETS OF LIBIDO

*by Herman Shankman*

As I rode out in the streets of Libido,  
as I rode out in Libido one day.  
I spied a young complex,  
all dressed in dream symbols,  
all dressed in dream symbols  
as cold as the clay.

So I said to my analyst,  
as I lay there dreaming,  
I wonder, I wonder, as every one does.  
If Freud was the Father of Psychoanalysis,  
then I wonder, I wonder, who its Mother was.

Now I've been through-  
Freud, Jung and Adler,  
but I'm only sadder;

All those years on the couch  
I've just wasted away;  
So now I take acid  
and Dexedrine--  
to remember where I have been;  
Now the streets of Libido--  
all look like Broadway, (lower voice)--  
yes the streets of Libido,  
all look like Broadway.

(Parodied to The Streets  
of Laredo)

light without dark glasses and despite daily amounts of cogentin, I regularly had spasmodic attacks, common side-effects of my medication. Most painfully, I was continually morose and unable to carry on even the basics of a friendly conversation. My friends finally stopped calling; as they later explained, it was too difficult for them to see me so sad, so remote.

My psychiatrist was either unwilling or unable to explain any of this to me. Rather, he would field any of my questions concerning my drugs, diagnosis or depression with counter-questions as absurd as, "Is there any other time in your past when you felt this way? or "Why do you want to know?". This Freudian gambit went on for quite some time.

Finally, I stopped taking the drugs. I thought, well, whatever happens, it can't be any worse than the way I feel now. Two months later, my moods had elevated, my sense of humor returned. Against the wishes of my therapist, I stopped attending my rehab programme. I scraped together some money and took a well-deserved vacation. On my return, I decided to take the plunge and I terminated therapy. I received anonymous letters from my psychiatrist who made veiled references to the certain breakdown that surely was in store unless I resumed our sessions.

Well, that breakdown never occurred. I have attended sessions with a therapist who is neither a psychiatrist nor psychologist. Through his aid and that of a sympathetic G.P., I have obtained my hospital records. Interestingly, my diagnosis was categorized under "Borderline Personality", a term my lay-therapist described as a "dumping ground" for all the cases too unique to easily slot. For that, I spent the better part of two years in depression and a drugged-out haze.

I am still angry. How difficult it is to focus my frustrations. The hospital is too large an institution. My doctor, well, his behaviour, in the professional standard, was beyond reproach.

This letter, written now, helps me deal with the anger and so, hopefully, I can lay aside and proceed with my life. Thank you for allowing me this opportunity.

*Paul Bartlet,  
Toronto, Ontario.*



I'd like to comment on the letter from Leonard Roy Frank, published on page 3 of

the last issue.

According to Leonard, "*Mental Illness is not a real disease*", and he quotes Dr. Szasz to prove it: "The mind ... is not an organ or part of the body. Hence, it cannot be diseased in the same sense as the body can."

This argument for the non-reality of mental disease is reminiscent of the old belief that mental disease is supernatural, and can be responded to in the same way:

"Mental diseases are brain diseases."

That particular succinct statement is from Wilhelm Griesinger's *MENTAL PATHOLOGY AND THERAPEUTICS*, written in the middle of the last century. It can be spelled out. The brain, which is an organ of the body, is "an immense reflex apparatus" and is also the organ of the consciousness--of the mind. Brain diseases are thus exhibited in disorders of sensation, movement or mentation. Conversely, mental disease is a class of brain disease.

## "How could Szasz have got so far...?"

Greisinger, a doctor in a German asylum, wrote of mental disease dispassionately and descriptively, he classified it by mental faculty or faculties disordered and enriched his own observations with his patients' self-observations. Throughout, he emphasized the physicalness of mental disease, not just in its relation to the brain but in the awesome effects of mental suffering upon the body. As to the causes of mental disease, he recognized both the emotional and the chemical, pointing out that a severe fright may cause death beginning at the brain or may simply wound the brain, and that a glass of wine provides "a weak analogy to insanity" in that it elevates the spirits without external cause for joy.

How could Szasz have got so far from his naturalistic view of mental disease as to hold that it is nonexistent and "a myth"?

The etiology of his position begins with Freud, who derailed observational brain science by re-disconnecting the mind from the brain. In Freud's view, mental disease was not a neurological but a psychological phenomenon. It was the product of *unconscious wishes*. A blow on the head might have a neuro-

logical effect, but otherwise the manifestations of mental disease were fulfillments of repressed pathological wishes. Psychoanalysis brings out the worst in every man," said Freud happily as he plumbed the unconscious for the illicit, ignoble, or other hidden motives that might be animating his patients. And if they didn't get well, it was because they wished to suffer on. At this point mental disease is neither supernatural nor organic but was the victim's *own fault*, though unconsciously. Freud gave contempt for mental patients a theoretical basis.

What Szasz did was to carry Freudianism a giant step further. He and his followers agree that what is called mental disease is but a psychological phenomenon, but they attribute it not to unconscious wishes but to *conscious wishes*. Thus Szasz can say that the man who claims to be Jesus Christ is lying, and that the woman who goes to a hospital in a state of depression is a weak and lazy creature, *wishing to escape responsibility*. In similar vein his erstwhile student Peter Breggin, in his recent book, speaks of people who 'choose' to be euphoric or 'choose' to be paranoid; and he would have it that people betake themselves to hospitals because of 'psychological incompetence'. The intense suffering which was for Greisinger the most conspicuous feature of mental disease; and which Freud at least recognized though he thought it showed masochism; Szasz and his followers are totally blind to. It's part of the myth.

At this point, mental disease reduces to moral deficiency - pure and simple. Some eccentrics, accidentally misclassified, are absolved for being mentally ill, but at the same time all the sick and suffering, plus of course the irrational, are condemned as being of bad character. In logic, permanent contempt and disgust for them are justified as is also Dr. Szasz's ominous term for psychiatrists--'moral agents'.

I say, let's chuck this balderdash and reinstate mental disease. Let's go back to the sympathetic outlook of old Griesinger and attempt, as he did, to figure out how the brain works by studying its fascinating malfunctions.

Marilyn Rice,  
Arlington, Virginia

Due to space limitations in this issue, we have temporarily suspended our classified ad section. It'll be back in our next issue along with a complete list of ON OUR OWN Pen Pals.

## DIRECTORY CONTINUED

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Germany.

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2600 Antwerpen-Belchem Station, Belgium.

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The publication of this magazine is made possible by a Canada Community Development Grant, and grants from Health and Welfare Canada and the Ontario Ministry of Culture and Recreation.

## Publications Available

Consumer's Guide to Psychiatric Medication (published by Project Release, New York). A concise and thorough description of psychiatric drugs and their effects and side-effects. \$2.50.

Myths of Mental Illness, by Carla McKague (**Phoenix Rising** Publication #1). An exploration of common beliefs about the "mentally ill"--are they really true? \$1.00.

Inmates' Liberation Directory. An up-to-date list of inmate-controlled groups and journals around the world. (Printed periodically in **Phoenix Rising**) 50¢.

On Our Own: Patient-Controlled Alternatives to the Mental Health System, by Judi Chamberlin (McGraw-Hill Ryerson). "Required reading for all 'mental health' professionals ... who still believe that 'mental patients' are too 'sick', helpless and incompetent to run their own lives." \$5.00 (list price \$6.95).

The History of Shock Treatment, edited by Leonard Roy Frank. A compelling and freightening collection of studies, first-person accounts, graphics and other material covering 40 years of shock treatment. \$6.00.

Don't Spyhole Me, by David Reville (**Phoenix Rising** Publication #2). A vivid and revealing personal account of six months in Kingston Psychiatric Hospital (included in this issue of **Phoenix Rising**). \$1.00.

Phoenix Rising, vol.1, no.2. Prison psychiatry; Thorazine; blindness and emotional problems; commitment; and more; \$2.50.

vol.2, no.5. Alderman David Reville's courageous account of his experiences in Kingston Psychiatric Hospital; The Tricyclics; Insurance and the Krever Commission; and more \$1.50.

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